# Mayfield CSD Health Services

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## STUDENT HEALTH HISTORY UPDATE

| | | |
|---|---|---|
| Name: | DOB: Age:<br>Grade: | Gender:<br>☐ M ☐ F |
| Pediatrician: | Phone: | |
| Parent/Guardian:<br>(person completing this form) | Home Phone:<br>Cell Phone: | Date: |

| **Has your child ever:** | **YES** | **NO** | **If Yes, please explain and include date:** |
|---|---|---|---|
| Had an ongoing medical condition | ☐ | ☐ | |
| Seen a medical specialist | ☐ | ☐ | |
| Any allergies | ☐ | ☐ | ☐food ☐environmental ☐insect ☐medication ☐other |
| Been hospitalization | ☐ | ☐ | |
| Had an operation | ☐ | ☐ | |
| Had an injury requiring an Emergency Room visit | ☐ | ☐ | |
| Missed 5 days of school in a row due to illness/injury | ☐ | ☐ | |
| Had a bone/muscle injury | ☐ | ☐ | |
| Passed out, had a concussion or serious head injury | ☐ | ☐ | |
| Had a convulsion/seizure | ☐ | ☐ | |
| Had a vision problem or condition | ☐ | ☐ | ☐ glasses ☐ contacts |
| Had a hearing problem or condition | ☐ | ☐ | ☐ hearing aid ☐ cochlear implant |
| Worn dental bridge, braces or mouthpiece | ☐ | ☐ | |
| **Have any family members under the age of 50 ever**: | **YES** | **NO** | **If Yes, please specify:** |
| Had a heart attack | ☐ | ☐ | |
| Had other serious health problems | ☐ | ☐ | |

**CHECK ALL THAT APPLY TO YOUR CHILD:**

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition

| **CURRENT MEDICATIONS** | **YES** | **NO** | **Please list name, dose, time(s)** |
|---|---|---|---|
| Given at school | ☐ | ☐ | |
| Taken at home | ☐ | ☐ | |
| **ASSISTIVE EQUIPMENT** | **YES** | **NO** | **Please check all that apply** |
| During or outside of school | ☐ | ☐ | ☐crutches ☐walker ☐wheelchair ☐other: |
| **TREATMENTS** | **YES** | **NO** | |
| During or outside of school | ☐ | ☐ | ☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet |

Is there any condition that would prevent your child from participating in physical education or sports?
☐No ☐Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

*Above information may be shared with appropriate school personal to ensure your child's safety unless otherwise requested.*

Parent/Guardian Signature: _____Date:_____

This sample resource was created by the New York State Center for School Health
and is located at www.schoolhealthny.com – Forms |Notifications – 8/14