B. Student History

Cardiovascular - Respiratory

Has your Child a History of:  
Yes  No

Heart or Lung Trouble
Chronic Tiredness
Murmur Heard by a Physician at any time
High Blood Pressure
Chest Pains with Exercise
Persistent Cough
Dizziness or Faintness With Exercise
Palpitations
Rapid or Irregular Heart Beats
Shortness of Breath
Wheezing With Exercise
Rheumatic Fever
Heart or Lung X-Rays For Any Reason
Electrocardiogram For Any Reason
Marfans Syndrome
Ehlers Danios Syndrome

BLOOD

Has Your Child a History of:
Tendency to Bleed or Bruise Easily
Anemia
Hepatitis
Mononucleosis

DIGESTIVE

Has Your Child a History of:
Frequent Pain in Abdomen
Ulcers
Colitis
Enteritis

NEUROLOGICAL

Has your Child a History of:
Brain Concussion (Head Injury)
Fainting Spells
Skull Fracture
Recurring Severe Headaches
Convulsions or Epilepsy
HUNTINGTON SCHOOL DISTRICT
Health Screening Form

Eyes-Ears-Nose-Throat
(Check One)
Yes No
Has Your Child a History of:
Very Bad Vision In One Eye
Temporary Loss of Vision
To Wear Glasses or Contact Lenses
Hearing Loss
Perforated Ear Drum
Discharge From an Ear
(Recurrent Infection)
Sinus Infection
Frequent Nose Bleeds
Broken Nose
Deviated Septum
Dental Plate (Dentures)
Orthodontia

Genito-Urinary
Has Your Child a History of:
Hernia
Blood, Pus, or Protein in Urine
Impaired Function or Loss of
A Kidney
Absence of Testicle
Menstrual Problems
Age At Onset of Menstruation

Orthopedic
Has Your Child A History Of:
Bone Fracture
Joint Dislocation

Foot Problems
Spine or Limb Deformity
Neck Injury
Back Injury or Frequent Backaches
Knee Injury (Sprain) or Recurrent Pain
Ankle Injury (Sprain) or Recurrent Pain
Other Joint Problems
Bone Infection

Allergy
Has Your Child Had
Hay Fever
Asthma
Frequent Hives or Rashes
Reaction to Medication
Reaction to Insect Stings
Does Your Child:
Take Any Medications Regularly
If Yes, Name__________________
Take Medication For Emergency Use
If Yes, Type__________________
Has Your Child Ever Had an Operation
If Yes, Name__________________
Has Your Child Ever Been
Hospitalized
Reason______________________
Has Your Child Ever Been Told to
Give Up Athletics Because of A Health
Problem
If Yes, Describe________________

If There Are Any Yes Answers to the Above Questions, Use the Space Below to Explain:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please Sign__________________________  Parent or Guardian__________________________  Date__________________________

In addition, if you wish your child to be examined by the school physician, you must also sign below.

Please Sign__________________________  Parent or Guardian__________________________  Date__________________________