HUNTINGTON SCHOOL DISTRICT
Health Screening Form

THIS FORM MUST BE COMPLETED AND SIGNED BY PARENT

Date _____

Student's Name _____

Address _____

Phone _____

Date of Birth _____ Grade _____

Date of Last Tetanus Booster _____
Notify in Case of Emergency (Parents' Business Phone)
_____
Authorized Alternates (Relatives, Friend, Neighbor)
_____
Family Doctor _____
Phone _____

A. General Family History

Please state who in Your Family (Parents, Aunts, Uncles, Cousins, Grandparents) Had or Now Has:

(Check One)
Yes **No**

1. Diabetes

Allergies: Hay Fever
Asthma
Frequent Hives or Rashes
Reaction to Medication
Reaction to Insect Stings
Migraine Headaches
Epilepsy

2. Has anyone in Your Family Under Age of 50 Died Suddenly?
If So, Indicate Cause _____

3. Has Anyone in Your Family Had or Now Has:
Tendency to Bleed
Anemia
Heart Disease
Stroke
Coronary Artery Disease
Rheumatic Fever
High Blood Pressure
Rhythm (Heart Beat) Disturbance
High Cholesterol in Blood
Has Anyone Had Tuberculosis

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

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	(Check One) Yes	No
Eyes-Ears-Nose-Throat		
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