

**MONTICELLO CENTRAL SCHOOL DISTRICT STUDENT HEALTH HISTORY**

**PRINT ONLY – Please write clearly**

Student's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender (circle): M F Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian (1) First Name: \_\_\_\_\_ Parent/Guardian (2) First Name: \_\_\_\_\_

Parent/Guardian (1) Last Name: \_\_\_\_\_ Parent/Guardian (2) Last Name: \_\_\_\_\_

Phone #s Parent/Guardian (1): \_\_\_\_\_ Phone #s Parent/Guardian (2): \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Work: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Emergency: (\_\_\_\_) \_\_\_\_\_ Emergency: (\_\_\_\_) \_\_\_\_\_

**YES NO Please answer all of the following:**

- 1. Has anyone in the student's family (grandmother/father, mother, father, brother, sister, aunt, uncle) died suddenly before 50 years of age?
- 2. Has the student ever passed out during exercise or stopped exercising because of dizziness?
- 3. Does the student have asthma (wheezing), hay fever, or coughing spells after exercise?
- 4. Has the student ever broken a bone, had to wear a cast, or had an injury to any joint? When? Explain: \_\_\_\_\_
- 5. Has the student ever had a concussion or been knocked unconscious?
- 6. Has the student ever suffered heat related illness (heat stroke)?
- 7. Do you have anything you would like to discuss with the school nurse?
- 8. Does the student have a chronic illness or see a physician regularly for any particular problem? Explain: \_\_\_\_\_
- 9. Does the student take any medication? If so, what kind and what dosage? \_\_\_\_\_
- 10. Is the student allergic to any medications, bee stings or foods? If so, what: \_\_\_\_\_
- 11. Does the student have only one of any paired organ? (eyes, ears, kidneys, testicles, ovaries, etc...)? Please list \_\_\_\_\_
- 12. Has the student missed 5 consecutive days of school, physical education, or sport due to illness/injury? Please explain: \_\_\_\_\_
- 13. Does the student have to wear contact lenses/glasses? Explain vision problem if any: \_\_\_\_\_
- 14. Has the student ever been hospitalized or had surgery? If so, when and why? \_\_\_\_\_
- 15. Does the student live with anyone who is immunosuppressed or suffering from a chronic illness? Please explain: \_\_\_\_\_

16. Please indicate if the student has had any of the following diseases. Include the approximate date.

<input type="checkbox"/> Disease	Date	<input type="checkbox"/> Disease	Date
<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Contact w/Tuberculosis	_____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Runny Ears (which ear)	_____
<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Scarlet Fever	_____
<input type="checkbox"/> Frequent Colds / Sore Throat	_____	<input type="checkbox"/> Serious Injury	_____
<input type="checkbox"/> German Measles	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Whooping Cough	_____
<input type="checkbox"/> Mumps	_____		
<input type="checkbox"/> Other serious illness not listed (Name of illness and date of occurrence): _____			

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_