Beacon City School District
Beacon, NY 12508

HEALTH HISTORY FORM

(To be completed by the Parent/Guardian)

Student's Name:_____DOB:_____ □M □F Grade:____

Has your child ever had:	NO	YES	Explain "Yes" answers
Allergies (food, insect, medication, other)			□ Epi-Pen □ Benadryl
Arthritis			
Anemia (or sickle cell disease)			
Asthma (or other respiratory conditions)			□ Inhaler □ Nebulizer
Back or Neck Conditions			
Bladder or Kidney Conditions (or only one kidney)			
Convulsions/Seizures/Epilepsy			
Dental Conditions (orthodontics, caps, bridge, mouthpiece)			
Diabetes			
Ear Conditions (or hearing loss)			
Eye Conditions (or uncorrectable loss of vision in one or both eyes)			□ Contacts □ Glasses
Fainting Episodes			
GI Conditions (stomach ulcer, IBS, reflux)			
Headaches/Migraines			
Head Injury (or concussion)			
Heart Conditions (murmur/chest pain/high blood pressure)			
Hernia (or Hernia Repair)			
Joint Injuries or Pain Specify left or right AND which joint was affected			
Mental Health Conditions			
Nose Fracture or Frequent/Severe Bleeds			
Physical limitations related to Physical Education or Sports			
Surgery or been hospitalized overnight			
Only one functional testicle			
Illness or injury, lasting more than 5 days, since his/her last physical exam?			
Does your child take any medication daily?			
Is there anything else the school nurse should know about your child?			
Child's Doctor (name)			Phone #
Child's Dentist (name)			Phone #

_____ _____ _____

Parent (Guardian) Print Name Parent (Guardian) Signature Date