NORTH SYRACUSE CENTRAL SCHOOL DISTRICT
HEALTH RECORD AND HISTORY FORM

Name:	DOB: Grade: Age:	Gender: □ M □ F
Parent/Guardian: (*person completing this form*)	Home Phone: Cell Phone:	Date:
Physician:	Phone #:	Date of last physical exam:

I give permission for the above student to have a school physical: □ ***YES*** □ ***NO***

Has your child ever:	**YES**	**NO**	**If YES, please explain and include date:**
Had an ongoing medical condition			
Seen a medical specialist			
Had allergies: *Food, Environment, Insect, Medication or Other*			
Been hospitalized			
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 or Color Blind*			
Had a hearing problem or condition: *Hearing Aid or 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 or other serious health Issues			

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

History of:

- □ Rheumatic Fever
- □ Chicken Pox
- □ Reoccurring Strep Throat
- □ Scarlet Fever
- □ Tuberculosis

CURRENT MEDICATIONS	**YES**	**NO**	**Please list: NAME/DOSE/TIME(S)**
Given at School			
Taken at Home			
ASSITIVE EQUIPMENT at SCHOOL	**YES**	**NO**	**Please Check All That Apply**
During or Outside of School:			□ Crutches □ Walker □ Wheelchair □ Other
TREATMENTS	**YES**	**NO**	**Please Check All That Apply**
During or Outside of School			□ Insulin □ Blood Glucose Monitoring □ Inhaler/Nebulizer/Peak Flow Monitoring □Special Diet

Has your child tested positive for COVID-19:

Yes: ____ No: ____ Date: _____

Is there any condition that would prevent your child from participating in physical education or sports? □ YES □ NO

_____

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

PARENT/GUARDIAN SIGNATURE_____DATE: _____