BELLEVILLE HENDERSON CENTRAL SCHOOL DISTRICT
8372 COUNTY ROUTE 75, ADAMS, NY 13605
Phone: 315-846-5411 Fax: 315-846-5617

HEALTH HISTORY

Student Name: DOB: Grade:

Address:

1st Parent/Guardian Name: Phone:

2nd Parent/Guardian Name: Phone:

Name of Physician: Dentist:

HAS YOUR CHILD EVER:	YES	NO	IF YES, PLEASE EXPLAIN AND INCLUDE DATES
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies/allergic reaction:	☐	☐	
Been Hospitalized	☐	☐	
Had Surgery	☐	☐	
Had an injury requiring an ER visit	☐	☐	
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
Had a hearing problem or condition	☐	☐	☐hearing aid ☐cochlear implant
Worn dental bridge/braces or mouthpiece	☐	☐	
HAS A RELATIVE HAD ANY OF THE FOLLOWING	**YES**	**NO**	
Heart attack at age 50 or younger?	☐	☐	
Pacemaker or implanted cardiac defibrillator (ICD)?	☐	☐	
Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy	☐	☐	
Arrhythmogenic Right Ventricular Cardiomyopathy?	☐	☐	
Heart rhythm problems: long or short QT interval?	☐	☐	
Brugada Syndrome?	☐	☐	
Catecholaminergic Ventricular Tachycardia?	☐	☐	
Marfan Syndrome (aortic rupture)?	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/Trouble Breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI (stomach) 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

Please list any additional concerns/factors which may have an effect on your child's performance at school: (use another sheet if necessary)

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PLEASE LIST CURRENT MEDICATIONS

Medication name	Dose	Time	Given at home	Given at School
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Does your child require any special needs/monitoring?

☐ Insulin/Blood Glucose Monitoring
☐ Inhaler/Nebulizer/Peak flow monitoring
☐ Dietary Restrictions:_____
***please be aware that any special dietary substitutions require a note from your physician/pediatrician*
☐ Other:_____

Other Concerns:

Any Present Difficulties: Check only if applies:

☐ Frequent Nightmares ☐ Bed Wetting ☐ Trips Easily ☐ Short attention Span
☐ Frequently hurts self ☐ Runs into things ☐ Trouble with stairs ☐ Unexplained temper tantrums

Any Other factors within the home that may have an effect on your child's performance here at school?

☐ Recent death in the family ☐ Frequent Moves ☐ Deployments ☐ Separation/Divorce
☐ Birth of Sibling
Other:_____

****Please provide the health office with a copy of your child's current physical from their medical provider. If medications are required during school hours, please discuss forms needed with the health office at 315-846-5323.**

If you are unavailable and your child needs to go home because of illness or injury, whom do we contact?

Name: Phone:
Name: Phone:

I give permission for medical and emergency information about my child to be shared with the school nurse. I also give permission for the school nurse to have my child transported to an emergency medical facility if deemed necessary.

Parent/Guardian
Signature:_____ Date:_____