CHATHAM CENTRAL SCHOOL
STUDENT HEALTH HISTORY

PLEASE PRINT CLEARLY

Student Name: _____ **Age:** _____ **DOB**: _____

Health History:

Were there any issues during pregnancy, labor and/or delivery for this child? ❑ Yes ❑ No
If yes, please describe: _____

Does this child have any ongoing health concerns? (asthma, diabetes, etc.) ❑ Yes ❑ No
If "yes", please describe: _____

_____

Does this child have any allergies?
Medications ❑ Yes ❑ No **Foods** ❑ Yes ❑ No **Insect Stings** ❑ Yes ❑ No
If "yes", please list: _____
Has the allergy required emergency treatment? ❑ Yes ❑ No
If "yes", please explain: _____

Does this child have a history of an elevated lead level? ❑ Yes ❑ No
Are the child's immunizations up to date? ❑ Yes ❑ No **Please provide a copy for health office**
Date of last physical _____ **Please provide a copy for health office**

Is there a history of any hospitalizations, significant injuries or surgery? ❑ Yes ❑ No
If "yes", please describe: _____

Are there any current medical concerns/injuries? ❑ Yes ❑ No
❑ Head _____ ❑ Eyes _____ ❑ Nose _____
❑ Ears _____ ❑ Throat _____ ❑ Neck _____
❑ Chest _____ ❑ Respiratory _____
❑ Cardiovascular _____ ❑ Gastrointestinal _____
❑ Genitourinary _____ ❑ Neurological _____
❑ Muscloskeletal (include any past fractures, etc.) _____

Does this child take any medication regularly at home? ❑ Yes ❑ No
Require medication at school? ❑ Yes ❑ No
If "yes", please describe: _____

Does this child have any vision or hearing deficits? ❑ Yes ❑ No
Require glasses or hearing aids at school? ❑ Yes ❑ No
If "yes", please describe: _____

Does this child have/had any speech or developmental delays? ❑ Yes ❑ No
Receive any services? ❑ Yes ❑ No
If "yes", please describe: _____
Any additional concerns or pertinent information (use back as needed):

Health Care Providers

Local Physician: _____ Phone: _____

Local Dentist: _____ Phone: _____

Required Physicals

Education law requires every child have a physical examination in kindergarten, 2nd, 4th 7th, and 10th grades, annually for sports participation, and to be screened for scoliosis in grades 5-9. If you prefer to have your child examined by your family physician, please send a copy of the report to school by September 30th. If a report of the physical exam is not received, we will schedule your child for a physical by the school physician.

(over)

Parent Authorization

I prefer to have my child examined by:

My family physician _____

The school physician _____

In case of serious accident or illness, I authorize the above named physician, dentist or hospital to treat my child in my absence.

_____ _____ _____

Signature of Person Completing Form **Relationship** **Date**

_____

Printed Name

Intraoffice Use Only

Medication authorization form provided	❑ Yes ❑ No
Physical appraisal form provided	❑ Yes ❑ No
Dental form provided	❑ Yes ❑ No
Form reviewed	❑ Yes ❑ No
Name/Title of Reviewer:_____	**Date:** _____

Revised 7/1/2014-mmh