Health History Questionnaire
Lyndhurst Public Schools

Student's Name: _____ Grade: _____ School Year: _____

Date of Birth: _____ Sex: _____

Student's Medical History
(to be completed by parent or physician)

	Yes	No	Date	Description/Reason
Allergies	☐	☐		
Asthma	☐	☐		
Blood Disorders	☐	☐		
Cancer	☐	☐		
Chicken Pox	☐	☐		
Diabetes	☐	☐		
Headaches	☐	☐		
Hearing Problem/Hearing Aid	☐	☐		
Heart Disease	☐	☐		
Hepatitis	☐	☐		
High/Low Blood Pressure	☐	☐		
Hospitalization	☐	☐		
Kidney/Urinary Tract Problem	☐	☐		
Medication Reactions	☐	☐		
Menstrual Disorder	☐	☐		
Mononucleosis	☐	☐		
Muscular Disorder	☐	☐		
Orthopedic Disorder	☐	☐		
Rheumatic Fever	☐	☐		
Scoliosis	☐	☐		
Seizure Disorder	☐	☐		
Strep Infections	☐	☐		
Surgery	☐	☐		
Ulcer/Gastrointestinal Disorder	☐	☐		
Visual Problem/Glasses/Contact Lenses	☐	☐		
Other	☐	☐		

Is the student under the care of a physician? Yes ☐ or No ☐ If yes, give reason below.

_____

Does the student take any regular medication? Yes ☐ or No ☐ Please name medication and dosage below.

_____

Has the student ever been advised by a physician not to play a sport? Yes ☐ or No ☐ If yes, give reason belo

_____

Are there any other physical or emotional conditions that might bear on this child's abilities or performance?

_____

ADDITIONAL COMMENTS: _____