

## Kingston City School District

### HEALTH HISTORY for REGISTRATION, ATHLETES, and GRADES 5 - 12

Please complete in blue or black ink.

Name:		DOB:	Age:	Gender:
School:		Grade:		<input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)		Home Phone:		Date:
		Cell Phone:		
<b>Has your child ever:</b>	<b>YES</b>	<b>NO</b>	<b>If Yes, please explain and include date:</b>	
Had an ongoing medical condition/medical specialist	<input type="checkbox"/>	<input type="checkbox"/>		
Had allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other	
Been hospitalization/Had an operation	<input type="checkbox"/>	<input type="checkbox"/>		
Had an injury requiring an Emergency Room visit	<input type="checkbox"/>	<input type="checkbox"/>		
Missed 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>		
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>		
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>		
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>		
Had a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts	
Had a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant	
Worn dental bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Cardiac History:</b>	<b>YES</b>	<b>NO</b>	<b>If Yes, please specify:</b>	
Has anyone in your immediate family had any serious cardiac history such as: heart attack or sudden cardiac death under the age of 50, irregular heart beat, pacemaker, cardiomyopathy, structural defects, genetic heart defects	<input type="checkbox"/>	<input type="checkbox"/>		
Has your student had any irregular heartbeats, symptoms during or after exercise, fainting	<input type="checkbox"/>	<input type="checkbox"/>		

**CHECK ALL THAT APPLY TO YOUR CHILD:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ADHD<br><input type="checkbox"/> Asthma/trouble breathing<br><input type="checkbox"/> Autism/Asperger<br><input type="checkbox"/> Dental Injuries<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Ear Infections | <input type="checkbox"/> GI Conditions (ulcer, reflux, IBS)<br><input type="checkbox"/> Headaches/migraines<br><input type="checkbox"/> Heart Conditions<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Mental Health Condition<br>(depression, eating disorder, anxiety, OCD, ODD, etc.) | <input type="checkbox"/> Scoliosis<br><input type="checkbox"/> Single Organ ( <input type="checkbox"/> kidney, <input type="checkbox"/> testicle)<br><input type="checkbox"/> Skin Condition<br><input type="checkbox"/> Speech Condition<br><input type="checkbox"/> Urinary Condition |
|--|--|---|

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet

Is there any condition that would prevent your child from participating in physical education or sports?

No  Yes: \_\_\_\_\_

Please list any additional concerns: (use back of sheet if necessary) \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_