Grade:

HEALTH HISTORY

To be completed by Parent/Guardian for in-school physical

STUDENT:_____ DOB: _____

	YES	NO	Explain
Allergies			
Anemia			
Arthritis			
Asthma			
Bladder/Kidney Problem			
Cardiac Problems: Arrhythmia/Murmur/chest pain			
Convulsions/Seizures			
Diabetes			
Elevated Blood Pressure			
Ear problems/Hearing Loss			
Eye Problems/Vision Loss			
Fainting Spells			
Fracture/Dislocation Bones			
Headaches			
Head Injury/Concussion			
Injury to Spleen			
Joint/Sprain/Ligament Injury			
Nose Bleeds/Frequent or Severe			
Rheumatic Fever			
Stomach Ulcer			

	Yes	No
Has your child been unconscious or lost memory from a blow to the head?		
One kidney…….		
One testicle……		
Has your child been ill for five (5) consecutive days in the past year? If yes please explain -		
Is your child taking any medications now?…… If so, what		
Has your child ever fainted during exercise?…… If so, explain….		
Has there ever been sudden death in a family member under fifty (50) years of age?……. If so, explain….		
Does your child have: orthodontic appliances?		
Capped teeth?		
Wear glasses or contact lenses for sports?		
Wear a hearing aid for sports?		
Do you have any worries about your child's health or other questions you would like to discuss with a doctor?		

I understand that the determination of physical maturity is a private examination involving inspection of breasts and genitals and will be done by a licensed school health professional. I request that this examination be done by the school district's physician and give my permission for the examination in school. Physical assessments may only be performed one time per grade by the school physician.

PARENT/GUARDIAN SIGNATURE:_____**Date**:_____