

Binghamton City School District
Binghamton, New York
Annual Health History For Students

Today's Date _____

Child's Name _____ Male _____ Female _____

Father's Name _____ Mother's First & Maiden Name _____

Child's Physician _____ Preferred Hospital _____

School(s) child previously attended:

School	Location	Dates and Grades

Brothers and Sisters (Oldest First)

Name	Date of Birth	Name	Date of Birth

Has your child had any of the following: P = Past C = Current

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Obesity | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Kidney Disease/Stones | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Loss of Stool | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> German Measles | <input type="checkbox"/> Loss of Urine | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Use of Alcohol and/or |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Goiter | <input type="checkbox"/> Measles | <input type="checkbox"/> Skin Problems, | <input type="checkbox"/> Drugs |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rashes, Boils | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> or Others | <input type="checkbox"/> Smokes/ | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Chews Tobacco | <input type="checkbox"/> (Pertussis) |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Other _____ |

Birth Weight: _____

Has your child ever been hospitalized for serious illness, surgery, or accident? Yes _____ No _____

Apgar Score _____

If yes, explain _____

Is your child currently taking any medication? Yes _____ No _____

If yes, Name of medication _____, Reason for taking medication _____

Will child need to take the medication at school? Yes _____ No _____ (A written separate doctor's order is required.)

Family Health History: Please list any health problems of immediate family members which may affect your child:

Allergies Cancer Heart Disease Other _____
 Asthma Diabetes High Blood Pressure _____

<i>Vision Problem</i>	<i>Hearing Problem</i>	<i>Dental Health</i>
Name of Specialist _____	Name of Specialist _____	Name of Dentist _____
Glasses or Contacts: Yes _____ No _____	Hearing Loss: Right Ear _____	Work Complete Yes _____ No _____
Date of last visit _____	Left Ear _____	Date of last visit _____
	Date of last visit _____	

Does your child have any allergies to food, medications, insects or substances? Yes _____ No _____

If yes, please state known allergen: _____

Is there anything regarding the health of this student including physical handicaps that the school should know in order to provide a better adjustment in the classroom or physical education program? Yes _____ No _____

If yes, please specify _____

(It is the responsibility of the parent/guardian to make the school aware of any major illness, surgery, or change in the health status of the student.)

The school has my permission, in an emergency when I cannot be contacted, to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child. I verify that the above information is true and correct and I understand that this information may be shared with personnel involved with my child.

Parent/Guardian Signature _____ Date _____