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

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

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 <u>separate</u> doctor's order is required.)

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

______ Allergies ______ Cancer ______ Heart Disease Other ____

______ Asthma ______ Diabetes ______ High Blood Pressure ____

Vision Problem	***Hearing Problem***	***Dental Health***
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 ___________________________________

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