Smithtown Christian School
Health Screening/Medical History Form -- Grades K - 6

It is the sole responsibility of the parent and/or guardian to furnish the Health Office with information regarding any change in the health status.

Name:_____**DOB:**___/___/____ **Grade:**_____

Sport:_____**School**_____

Parent/Guardian: Answer the following questions as accurately as possible with details if needed.

1. Has student suffered any head injuries/concussions with or without loss of consciousness during his/her lifetime? Yes/ No When? _____ Did loss of consciousness occur? Yes/ No
Describe event:_____
_____

2. Any broken bones, fractures, surgery? Yes/ No When?_____
Describe_____

3. Any other injury requiring medical attention/hospital visit? Yes/ No When?_____

Describe_____

4. History of heart murmur? Cardiac Arrhythmia? Palpitations? Yes/ No Describe_____

_____

5. Asthmatic? Yes/ No Requires an inhaler for sports/exercise? Yes/ No Describe_____
_____

6. Any other chronic diseases or ailments? Yes/ No Describe_____

_____

7. Any fainting/ dizziness/fatigue after exertion? Yes/ No Describe_____
_____

8. Taking Medications at this time? Yes/ No
Describe_____

9. Allergies? Yes/No (*Medications, foods, environment, etc.*)
Describe_____

10. Glasses/contact lenses: Yes/ No Protective eyewear needed? Yes/ No
Orthodontic appliance Yes /No

11. Any other conditions or impairment (*vision, speech, hearing, scoliosis, etc.*) that the health office should be aware of? Yes/ No
Describe_____

12. Any handicapped conditions or need for special services or therapy? Yes/ No
Describe_____

Parent or Guardian
signature:_____Date:_____

Revised 1/10/18

Smithtown Christian School

SECONDARY Grades 7-12

HEALTH SCREENING/MEDICAL UPDATE

Both pages must be completed

Date:

Student Name:	**DOB:**
School Name:	**Age:**
Grade: **Sport:**	
Date of last health exam:	

Health History To Be Completed By Parent/Guardian, Provide Details to Any Yes Answers on Back
Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

Has/Does your child:

General Health Concerns	Yes or No
1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?	
2. Have an ongoing medical condition? __Asthma, __Diabetes, __Seizures, __Sickle Cell trait or disease, Other_____	
3. Ever had surgery?	
4. Ever spent the night in a hospital?	
5. Been diagnosed with Mononucleosis within the last month?	
6. Have only one functioning kidney?	
7. Have a bleeding disorder?	
8. Have any problems with his/her hearing or wears hearing aid(s)?	
9. Have any problems with his/her vision or has vision in only one eye?	
10. Wear glasses or contacts?	
Allergies	**Yes or No**
11. Have a life threatening allergy ? **If yes, please specify:**	
12. Carry an epinephrine auto-injector?	
Breathing (Respiratory) Health	**Yes or No**
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?	
14. Wheeze or cough frequently during or after exercise?	
15. Ever been told by their health care provider they have asthma?	
16. Use or carry an inhaler or nebulizer?	
Concussion/Head Injury History	**Yes or No**
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?	
18. Have you ever had a head injury or concussion?	
19. Ever had headaches with exercise?	
20. Ever had any unexplained seizures?	
21. Currently receive treatment for a seizure disorder or epilepsy?	

Has/Does your child:

Devices/Accommodations	Yes or No
22. Use a brace, orthotic or other device?	
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes, there may be need for another required form to be filled out.	
24. Wear protective eyewear, such as goggles or a face shield?	
Family History	**Yes or No**
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome or catcholamingeric polymorphic ventricular tachycardia?	
Females Only	**Yes or No**
26. Begun having her period?	
27. Age period began:	
28. Have regular periods?	
29. Date of last menstrual period:	
Males Only	**Yes or No**
30. Have only one testicle?	
31. Have groin pain or a bulge or hernia in the groin?	
Heart Health	**Yes or No**
32. Ever passed out during or after exercise?	
33. Ever complained of light headedness or dizziness during or after exercise?	
34. Ever complained of chest pain, tightness or pressure during or after exercise?	
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have pacemaker?	
36. Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?	

HEALTH SCREENING/MEDICAL UPDATE - PAGE 2

Student Name:	DOB:
School Name:	Age:

Heart Health *continued*	Yes or No
37. Ever been told they have a heart condition or problem by a physician? If so, check all that apply	
Heart Infection	
Heart Murmur	
High Blood Pressure	
Low Blood Pressure	
High Cholesterol	
Kawasaki Disease	
Other	

Injury History	Yes or No
38. Ever been diagnosed with a stress fracture?	
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?	
40. Ever had an injury, pain or swelling of joint that caused him/her to miss practice or a game?	
41. Have a bone, muscle or joint injury that bothers him/her?	
42. Have joints become painful, swollen, warm, or red with use?	

Skin Health	Yes or No
43. Currently have any rashes, pressure sores, or other skin problems?	
44. Have had a herpes or MRSA skin infections?	

Stomach Health	Yes or No
45. Ever become ill while exercising in hot weather?	
46. Have a special diet or have to avoid certain foods?	
47. Have to worry about his/her weight?	
48. Have stomach problems?	
49. Have you ever had an eating disorder?	

Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known)

Parent/Guardian Signature:	Date: