HUNTINGTON SCHOOL DISTRICT
Health Screening Form
THIS FORM MUST BE COMPLETED AND SIGNED BY PARENT

Date ______________________________

Student's Name ______________________

Address ___________________________

Phone ____________________________

Date of Birth __________ Grade ________

Date of Last Tetanus Booster __________
Notify in Case of Emergency (Parents' Business Phone)
____

Authorized Alternates (Relatives, Friend, Neighbor)
____

Family Doctor ______________________
Phone ____________________________

A. General Family History

Please state who in Your Family (Parents, Aunts, Uncles, Cousins, Grandparents) Had or Now Has:

(Check One)

	Yes	No
1. Diabetes		
Allergies: Hay Fever		
Asthma		
Frequent Hives or Rashes		
Reaction to Medication		
Reaction to Insect Stings		
Migraine Headaches		
Epilepsy		
2. Has anyone in Your Family Under Age of 50 Died Suddenly?		
If So, Indicate Cause ____________		
3. Has Anyone in Your Family Had or Now Has:		
Tendency to Bleed		
Anemia		
Heart Disease		
Stroke		
Coronary Artery Disease		
Rheumatic Fever		
High Blood Pressure		
Rhythm (Heart Beat) Disturbance		
High Cholesterol in Blood		
Has Anyone Had Tuberculosis		

B. Student History

Cardiovascular - Respiratory

Has your Child a History of:	Yes	No
Heart or Lung Trouble		
Chronic Tiredness		
Murmur Heard by a Physician at any time		
High Blood Pressure		
Chest Pains with Exercise		
Persistent Cough		
Dizziness or Faintness With Exercise		
Palpitations		
Rapid or Irregular Heart Beats		
Shortness of Breath		
Wheezing With Exercise		
Rheumatic Fever		
Heart or Lung X-Rays For Any Reason		
Electrocardiogram For Any Reason		
Marfans Syndrome		
Ehlers Danios Syndrome		
BLOOD		
Has Your Child a History of:		
Tendency to Bleed or Bruise Easily		
Anemia		
Hepatitis		
Mononucleosis		
DIGESTIVE		
Has Your Child A History of:		
Frequent Pain in Abdomen		
Ulcers		
Colitis		
Enteritis		
NEUROLOGICAL		
Has your Child a History of:		
Brain Concussion (Head Injury)		
Fainting Spells		
Skull Fracture		
Recurring Severe Headaches		
Convulsions or Epilepsy		

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Eyes-Ears-Nose-Throat	(Check One) **Yes**	**No**
Has Your Child a History of:		
Very Bad Vision In One Eye		
Temporary Loss of Vision		
To Wear Glasses or Contact Lenses		
Hearing Loss		
Perforated Ear Drum		
Discharge From an Ear (Recurrent Infection)		
Sinus Infection		
Frequent Nose Bleeds		
Broken Nose		
Deviated Septum		
Dental Plate (Dentures)		
Orthodontia		

Genito-Urinary

Has Your Child a History of:
- Hernia
- Blood, Pus, or Protein in Urine
- Impaired Function or Loss of A Kidney

Absence of Testicle

Menstrual Problems

Age At Onset of Menstruation ______

Orthopedic

Has Your Child A History Of:
- Bone Fracture
- Joint Dislocation

Foot Problems

Spine or Limb Deformity

Neck Injury

Back Injury or Frequent Backaches

Knee Injury (Sprain) or Recurrent Pain

Ankle Injury (Sprain) or Recurrent Pain

Other Joint Problems

Bone Infection

Allergy

Has Your Child Had
- Hay Fever
- Asthma
- Frequent Hives or Rashes
- Reaction to Medication
- Reaction to Insect Stings

Does Your Child:
- Take Any Medications Regularly
  If Yes, Name ____________________
- Take Medication For Emergency Use
  If Yes, Type ____________________
- Has Your Child Ever Had an Operation
  If Yes, Name ____________________
- Has Your Child Ever Been Hospitalized
  Reason ____________________
- Has Your Child Ever Been Told to Give Up Athletics Because of A Health Problem
  If Yes, Describe ____________________

If There Are Any Yes Answers to the Above Questions, Use the Space Below to Explain:

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____

Please Sign ______________________________ ______________________

Parent or Guardian **Date**

In addition, if you wish your child to be examined by the school physician, you must also sign below.

Please Sign ______________________________ ______________________

Parent or Guardian Date