School Health Service
Huntington Public Schools
Huntington, New York 11743

HEALTH SCREENING FORM
GREENKILL

Student's Name_____ Date_____

Address_____Phone_____

Date of Birth_____ Grade _____

Date of Last Tetanus Booster_____

Notify in Case of Emergency (Parent's Business Phone)_____

Authorized Alternates (Relatives, Friend, Neighbor)_____

Family Doctor_____Phone_____

A. General Family History

Please State Who In Your Family (Parents, Grandparents, Aunts, Uncles) Had Or Now Has:
(Please Specify Maternal or Paternal Relative)

	(Check One) Yes	No	Who (Please Explain)
1. Diabetes	☐	☐	_____
Allergies: Hay Fever	☐	☐	_____
Frequent Hives or Rashes	☐	☐	_____
Reaction to Medication	☐	☐	_____
Reaction to Insect Stings	☐	☐	_____
Migraine Headaches	☐	☐	_____
Epilepsy	☐	☐	_____
2. Has Anyone in Your Family Under the 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	☐	☐	_____
Tuberculosis	☐	☐	_____

B. Student History

Cardiovascular – Respiratory

Has your Child had 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	☐	☐
Dizziness or Faintness With Exercise	☐	☐
Persistent Cough	☐	☐
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	☐	☐

Eyes – Ears – Nose - Throat

Has Your Child A History Of:

Very Bad Vision in One Eye	☐	☐
Temporary Loss of Vision	☐	☐
Wearing 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	☐	☐
Other Joint Problems	☐	☐
Bone Infection	☐	☐

Allergy

Has Your Child A History Of:

Hay Fever	☐	☐
Asthma	☐	☐
Frequent Hives or Rashes	☐	☐
Reaction to Medication	☐	☐
Reaction to Insect Stings	☐	☐

Does Your Child:

Take Any Medication 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	☐	☐
If Yes, 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 Student History Questions Use The Space Below To Explain:

_____
_____
_____
_____
_____
_____

Please Sign _____ _____
Parent or Guardian Date

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

Please Sign _____ _____
Parent or Guardian Date