SACKETS HARBOR CENTRAL SCHOOL

A health history is part of the student's evaluation. It helps to provide a complete overview of your child and to access health/educational needs

Health History (To be completed by a parent or guardian)

Name:_____ Date of Birth:_____
First Middle Last

Address:_____ Phone:_____

BIRTH HISTORY:

Prenatal care started at _____months. Problems during pregnancy were _____

____ Labor & delivery healthy Born at ____months Weighed ___lb. ___ oz. C-Section because _____

____ Difficult Delivery? _____

Describe any newborn complications, breathing problems, trauma, or special needs:

_____

Did your child require a longer hospital stay?_____ If so why?_____

_____

GROWTH & DEVELOPMENT

Were there any early childhood concerns about your child?_____

Age: Crawler @ ____ Walked @ ____ Talked (words@ ____ sentences @ ____) Toilet Trained @ _____

Wet bed until age ____ Soiled pants until age ____

Describe balance, coordination, or muscle concerns _____

Vision problems: Explain _____

Hearing problems: _____ Many ear infections (ages _____) Tubes @ age _____

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CURRENT HEALTH

Date of last dental care _____ Problems? _____ Routine Exam? Yes____ No ____
Date of last physical exam _____ Problems? _____ Routine Exam? Yes ____ No ____

Child's pediatrician/physician:_____ Phone: _____
Child's dentist: _____ Phone: _____

Is your child capable of participating in a full program of school activities including recess and physical education: ☐ Yes ☐ No If no, please explain_____

CURRENT HEALTH CONCERNS	SELECT ONE		IF YES, PLEASE EXPLAIN
	NO	YES	
Does your child have any allergies?	☐	☐	☐ FOOD ☐ INSECTS ☐ MEDICATIONS ☐ OTHER
Is your child taking any prescribed medications on a daily bases?	☐	☐	
Will your child be taking any medication at school?	☐	☐	
Does your child have asthma?	☐	☐	
Does your child have diabetes?	☐	☐	
Does your child have a chronic illness or condition?	☐	☐	
Does your child have headaches?	☐	☐	
Does your child have bowel or bladder problems?	☐	☐	
PAST HEALTH CONCERNS	**SELECT ONE**		**IF YES, PLEASE EXPLAIN**
	NO	**YES**	
Does your child have any history of heart problems?	☐	☐	
Has your child ever had surgery?	☐	☐	
Has your child ever been hospitalized?	☐	☐	
Has your child ever had seizures?	☐	☐	
Has your child ever had chicken pox?	☐	☐	

IMMUNIZATIONS: New York law requires that all children enrolling in public school be immunized. A copy of your child's immunization record is required to be on file within 30 days after the start date of school.

NUTRITION: Appetite is ___ Good ___ Fair ___ Poor ___ Picky. Drinks mostly _____ Is vegetarian _____
Weight/Eating concerns? _____
Eats breakfast ___ Usually ___Sometimes ___ Never. Snacks mostly on _____
Daily has: ____ Protein/Meat ____ Veggies ____Fruits ____Grains ____ More than one soda/day ____ Too many sweets
Meals family eats together? ___ Breakfast ___ Dinner ___ Weekends only ___ Eats on our own ___ Usually watch TV at meals

FITNESS: Student is physically ___ Quiet ___Active ___Very Active ____hours of TV/Computer/videos per day
Prefers to do things ___ Indoors ___ Outdoors ___Both Usually does activities ___ Alone ___ With Friends ___ Both
List organized/team sports _____ ___ At school ___ Outside school
Describe exercise/fun activities _____
Describe social interactions _____

SLEEP: On school nights: Asleep by _____PM Up by ____AM _____ Has trouble sleeping ____ Has nightmares
____ Stays up too late ____ Often has trouble getting up in the morning ____ Often seems tired during the day
Other sleep concerns _____

Explain SIGNIFICANT STRESSES (emotional concerns in student's life – family, school, friends, abuse, losses, etc.)
_____
_____
Describe Counseling ☐ Past ☐ Current Name of Counselor _____
_____
Describe attitude toward school _____

DESCRIBE OTHER CONCERNS YOU HAVE ABOUT YOUR STUDENT _____
_____
_____
Do you need assistance in meeting your student's physical/dental/mental/other health concerns? If so, describe:
_____

HEALTH HABITS – MIDDLE AND HIGH SCHOOL ONLY

Describe any employment _____
Number of hours student works _____Weekdays ____ Weekends ____Evenings
Do you have any concerns about your student regarding the following areas?
☐ Cigarettes ☐Street Drugs ☐Chewing tobacco ☐Sexual activity ☐Alcohol ☐Driving Safety
If yes, explain _____
_____

_____ _____
Parent Signature **Date**

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