CONFIDENTIAL **ITHACA CITY SCHOOL DISTRICT** DATE: _____

HEALTH HISTORY

CHILD'S NAME: _____ BIRTHDATE: _____

Male: ____ Female: ____ Birth Place (City, State): _____

PARENT/GUARDIAN

NAME: _____

Email: _____ Phone Number: _____

PARENT/GUARDIAN

NAME: _____

Email: _____ Phone Number: _____

CHILD LIVES WITH: Father ____ Mother ____ Both ____

Other: ____ Name: _____ Relationship: _____

Child's Health Insurance

☐ Child Health Plus ☐ Medicaid ☐ Private Insurance ☐ No Insurance

Medical and Dental Information

Doctor _____ Date of last exam: _____

Dentist: _____ Date of last exam: _____

Names and date of birth of other children living in the home:

1. _____ DOB: _____ 2. _____ DOB: _____

3. _____ DOB: _____ 4. _____ DOB: _____

Previous Schooling

Did your child attend day care or nursery school? Yes ___ No ___If yes, where? _____

What is the last school your child attended? Name of School: _____

City: _____ State: _____

Has your child previously attended a school in the ICSD? Yes ___ No ___If yes, where? _____

Do you have any concerns about your child attending school? _____

PROCEDURE FOR EMERGENCY HEALTH CARE

Please fill in the names of two nearby relatives or friends who can be contacted in the event of your child's illness or injury at a time when you are difficult to locate

1. Name: _____

   Address: _____ Daytime Phone: _____

2. Name: _____

   Address: _____ Daytime Phone: _____

PLEASE COMPLETE REVERSE SIDE

CONFIDENTIAL

Child's Name: _____

Please answer the following questions, and explain all "YES" answers below. Feel free to circle specific information.

1. Has your child had an illness or injury since his/her last physical?	Yes	No
2. Does your child have an ongoing or chronic illness?	Yes	No
3. Has your child ever been hospitalized?	Yes	No
4. Has your child ever had surgery? What and When?	Yes	No
5. Does your child take any prescription or non-prescription medications? Vitamins? Fluoride? Other?	Yes	No
6. Does your child have any allergies *(for example: pollen, medicine, food)*?	Yes	No
7. Has your child been stung by a bee or wasp? What was the reaction to the sting? Redness ___ Swelling ___ Breathing Problems ___ Has your doctor prescribed emergency medication for stings? Yes No	Yes	No
8. Does your child ever get a rash or hives?	Yes	No
9. Has your child had chicken pox?	Yes	No
10. Has your child ever fainted or been dizzy during exercise?	Yes	No
11. Has your child ever had chest pain during or after exercise?	Yes	No
12. Have you been told your child has a heart murmur or heart problems?	Yes	No
13. Have you been told your child has high or low blood pressure?	Yes	No
14. Does your child get frequent or severe nose bleeds?	Yes	No
15. Does your child have problems with his/her bladder or kidney?	Yes	No
16. Does your child have problems with constipation or diarrhea?	Yes	No
17. Does your child have any skin problems *(for example: Itching, rashes, acne, warts)*?	Yes	No
18. Has your child ever had a head injury or concussion?	Yes	No
19. Does your child ever get headaches?	Yes	No
20. Has your child ever had a seizure?	Yes	No
21. Has your child ever complained of numbness or tingling in the arms, legs, hand or feet?	Yes	No
22. Does your child have asthma or reactive airway disease?	Yes	No
23. Does your child take asthma medication, use an inhaler or nebulizer?	Yes	No
24. Does your child cough, wheeze or have trouble breathing during or after activity?	Yes	No
25. Does your child use any special protective or corrective equipment *(for example: back brace, orthotics, hearing aid)?*	Yes	No
26. Has your child had any problems with his/her eyes or vision or wear glasses?	Yes	No
27. Has your child had any problems with hearing or have tubes in his/her ears?	Yes	No
28. Has your child had dental cavities or problems with teeth or gums?	Yes	No
29. Has your child had any broken bones or problems with pain or swelling in muscles, bones or joints?	Yes	No
30. Do you feel your child is underweight or overweight?	Yes	No
31. Do you feel your child experiences stress, anxiety or get emotionally upset easily?	Yes	No
32. (**For Girls ONLY**) Has your daughter had her menstrual period? If yes, when was her first menstrual period? Age: _____ How many days does her period last? _____ When was her last period? _____ Do you have any concerns about her menstrual period? Yes No	Yes	No
33. Is there a family history of sudden cardiac death?	Yes	No
34. Do you have any other concerns about your child's health?	Yes	No
Please use this space to *explain* any "YES" answers: _____ _____ _____		

PARENT/GUARDIAN SIGNATURE: _____ ***DATE:*** _____