Baldwinsville Central Schools
Student Health History Report

Student Name (last, first, MI)_____ **Birth Date** _____

Physician Name **Phone** **Dentist Name** **Phone**

_____ _____ _____ _____

Is there a physical condition or medical history? If yes, please explain

_____

Is your child on medication? If yes, please provide medication name

_____

Are there any health restrictions? If yes, please explain _____

Please check if your child has had any of the following:

☐ Allergies ☐ Anemia ☐ Asthma ☐ Convulsions/Seizures ☐ Depression

☐ Diabetes ☐ Difficulty Sleeping ☐ Eczema ☐ Encopresis (soiling) ☐ Enuresis (wetting)

☐ Head Injury ☐ Fractures (Broken Bones) ☐ Frequent Ear Infections ☐ Glasses/Contact Lenses ☐ Extreme Activity/Restlessness

☐ Hearing Problems ☐ Heart Murmur/defect ☐ Kidney Disease ☐ Lead Poisoning ☐ Dental Problems

☐ Serious Injury ☐ Temper Tantrums ☐ Urinary Tract Infections ☐ Vision Problems

***Please provide dates if your child has had any of the following illnesses*:**

Chicken Pox_____ Measles_____ Mumps _____ Scarlet Fever _____

Fifth's Disease_____ Meningitis _____ Pneumonia _____ Tuberculosis_____

Hepatitis_____ Mononucleosis _____ Rheumatic Fever _____ Whooping Cough _____

Please list any Hospitalizations and/or Operations:

_____

At Birth, my child's weight: _____lbs./oz. *The pregnancy and/or delivery were affected by the following factors (check all that apply)*:

☐ Prematurity ☐ Long Labor ☐ RH Factor ☐ Cesarean Section ☐ Incubator/Oxygen ☐ Alcohol During Pregnancy

☐ Smoking During Pregnancy ☐ Breech Birth ☐ Jaundice ☐ Mother ill during pregnancy (Please explain)

_____

Early Development: *Check areas that your child may have been delayed (this information intended for students entering elementary school):*

Age Crawled _____ Age Walked _____ Age Talk-Sentence _____ Age Toilet Trained: Bladder _____ Bowel _____

Family Health History: *(Check any that apply)*

☐ Alcoholism ☐ Blindness ☐ Deafness ☐ Diabetes ☐ Heart Condition ☐ Scoliosis ☐ Anxiety/panic disorder

☐ Allergies ☐ Asthma ☐ Cancer ☐ Depression ☐ Epilepsy ☐ Tuberculosis

Special Clinics Child has Attended: *(Check any that apply)*

☐ Hearing ☐ Heart ☐ Speech ☐ Orthopedic ☐ Mental Health ☐ Other _____

Parent/Guardian Signature _____ ***Date*** _____