

Iona Prep

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CITY SCHOOL DISTRICT OF NEW ROCHELLE
HEALTH SERVICES DEPARTMENT

STUDENT HEALTH HISTORY

Name:	DOB:	Age:	Gender:
Parent/Guardian Name:	Grade:	Home Phone:	Cell:
	Email:		Date:

Your Child's Medical History	YES	NO	If Yes, please explain and include date:
Born premature or had complications after birth	<input type="checkbox"/>	<input type="checkbox"/>	
Has an ongoing medical or developmental condition	<input type="checkbox"/>	<input type="checkbox"/>	
Sees a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>	
Has severe allergies or anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Food <input type="checkbox"/> Environmental <input type="checkbox"/> Insect <input type="checkbox"/> Medication <input type="checkbox"/> Other Specify:
Has been hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	
Had an operation/required surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Had an injury requiring an Emergency Room visit	<input type="checkbox"/>	<input type="checkbox"/>	
Missed 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>	
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a convulsion, has a seizure disorder , or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Has a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts
Has a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant
Wears a dental bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>	
Have any family members under the age of 50 ever:	YES	NO	If Yes, please specify:
Had a heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Had other serious health problems	<input type="checkbox"/>	<input type="checkbox"/>	

CHECK ALL THAT APPLY TO YOUR CHILD:

- | | | |
|--|---|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> GI Conditions (ulcer, reflux, IBS) | <input type="checkbox"/> Scoliosis/Orthopedic Impairment |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Single Organ (<input type="checkbox"/> kidney, <input type="checkbox"/> testicle) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Autism | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Speech Condition |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Health Condition | <input type="checkbox"/> Urinary Condition |
| <input type="checkbox"/> Ear Infections | (Depression, eating disorder, anxiety, OCD, ODD, etc.) | <input type="checkbox"/> EI/CPSE/CSE services _____ |

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐ No ☐ Yes: _____

Please list any additional concerns:

Parent/Guardian Signature: _____ Date: _____