

**New Roots Charter School
HEALTH HISTORY**

Today's Date _____		Home Phone# _____	
Student's Name _____		Birth date _____	
Male ___ Female ___	Birthplace (city, state) _____		Birth weight _____
Address _____		City _____	Zip _____
Parent/Guardian (name) _____		Employer _____	
		Work Phone# _____	
Parent/Guardian (name) _____		Employer _____	
		Work Phone# _____	
Child lives with: Father ___ Mother ___ Both ___			
Other ___		Name _____	
Employer _____		Relationship _____	
		Work Phone# _____	
Previous school attended _____		Address _____	
City _____		State _____ Zip _____	
Pre-school attended? ___ Name of school _____			
Has your child ever attended an Ithaca School? Yes ___ No ___ Name of School _____			
Doctor _____		Date of last exam _____	
Dentist _____		Date of last exam _____	
<u>Names and birth-dates</u> of other children living in the home:			
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 _____		Daytime phone _____	
Address _____			
2) Name _____		Daytime phone _____	
Address _____			

PLEASE COMPLETE THE MEDICAL HISTORY ON THE BACK

New Roots Charter School HEALTH HISTORY

Child's Name: _____ **Birth Date:** _____

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 & when? _____ yes___ no___
- 5) Does your child take any prescription or nonprescription medications? _____ Vitamins? _____ Fluoride? _____ yes___ no___
- 6) Does your child have any allergies (for example: pollen, medicine or food)? yes___ no___
- 7) Has your child been stung by a bee or wasp?.....yes___ no___
 What was the reaction to the sting? Redness? _____ Swelling? _____ Breathing difficulties? _____
 Does your doctor prescribe emergency medication for stings? 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 had chest pain during or after exercise?..... yes___ no___
- 12) Have you been told your child has a heart murmur, or other 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 kidneys?..... 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, fungus or blisters)?..... 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 arms or legs, hands or feet?..... yes___ no___
- 22) Does your child have asthma or reactive airway disease?..... yes___ no___
- 23) Does your child use an asthma medication 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 his/her hearing, or have tubes in his/her ears?..... yes___ no___
- 28) Has your child had dental cavities or problems with his/her 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 over or under weight?..... yes___ no___
- 31) Do you feel your child is stressed out, or emotionally upset?..... yes___ no___
- 32) *(for girls only)* Has your daughter started her menstrual period?..... yes___ no___
 If yes: When was her first menstrual period? Age _____ When was her most recent period? _____
 How many days does the period last? _____ Do you or she have concerns about her menstrual periods?..... yes___ no___
- 33) Is there family history of any of the following medical problems? (Circle any that apply.).....yes___ no___
 Diabetes, Heart disease, Sudden cardiac death, Seizure disorder, Emotional disorders, Developmental disorders, High blood pressure,
 Allergies,
 Other _____
- 34) Do you have any other concerns about your child's health? _____

Explain all "yes" answers:

Parent/Guardian's signature _____ **Date** _____

PLEASE COMPLETE OTHER SIDE