

**WEST ALLEGHENY SCHOOL DISTRICT  
STUDENT HEALTH HISTORY**

**PLEASE NOTE:** This form must be completed and signed by the Parent/Guardian before a student receives a school physical

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

GRADE: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

Has this student ever had any:	No	Yes	Explain
1. Chronic or recurrent illness? (i.e., Diabetes, Cystic Fibrosis, etc.)	[ ]	[ ]	_____
2. Illness lasting more than one week?	[ ]	[ ]	_____
3. Hospitalizations (overnight or prolonged stay in hospital)?	[ ]	[ ]	_____
4. Surgery or operation?	[ ]	[ ]	_____
5. Missing organs or loss of organ function (eyes, kidneys, testicle)?	[ ]	[ ]	_____
6. Allergic reactions to any medicine?	[ ]	[ ]	_____
7. Heart murmur, heart abnormality, or blood pressure problems?	[ ]	[ ]	_____
8. Seizure or convulsions?	[ ]	[ ]	_____
9. Dizziness, chest pain or fainting with exercise?	[ ]	[ ]	_____
10. Concussion or loss of consciousness?	[ ]	[ ]	_____
11. Broken or injured bones or joints?	[ ]	[ ]	_____
12. Emergency Room visits?	[ ]	[ ]	_____
13. Asthma or breathing problems?	[ ]	[ ]	_____
14. Liver or spleen enlargement?	[ ]	[ ]	_____
15. Serious injury or illness participating in a sport?	[ ]	[ ]	_____
16. Menstrual problems? (Females only)	[ ]	[ ]	_____

Has this student ever had any:

- |                                  | No                       | Yes                      | Explain |
|----------------------------------|--------------------------|--------------------------|---------|
| 17. Neck injury?                 | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| 18. Serious bleeding tendencies? | <input type="checkbox"/> | <input type="checkbox"/> | _____   |
| 19. Skin problems?               | <input type="checkbox"/> | <input type="checkbox"/> | _____   |

Does this student:

- |   |                          |                          |                |
|---|--------------------------|--------------------------|----------------|
| 20. Take any medications?   | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| 21. Have any allergies? (i.e., hay fever)   | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| 22. Wear glasses or contact lenses?   | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| 23. Wear braces, plates or other artificial devices?  | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| 24. Appear physically immature when compared to other children the same age?  | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| 25. Have any current injury?  | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| 26. Have any muscle pull?   | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| 27. Have any pinched nerve?   | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| 28. Have any back injury?   | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| 29. Who is child's doctor?<br>(name, address, phone number)   |                          |                          | _____<br>_____ |
| 30. Please list any family members who have had a heart attack, high blood pressure or high cholesterol or unexplained sudden death before 55 years of age. |                          |                          | _____<br>_____ |
| 31. Date of last known Tetanus shot?  |                          |                          | _____          |
| 32. Is this child physically and mentally able to participate in sports?  |                          |                          | _____          |

I give my permission for my child to receive a physical examination by the school physician.

PARENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

DAYTIME PHONE NO. \_\_\_\_\_ (so parent can be reached with any questions)