Eastminster School
Student Health History

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____ Extracurricular Activities_____

Address_____ Phone _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____

Phone (H) _____ Phone (W) _____

Explain "Yes" answers below.
Circle questions you don't know the answers to.

To be filled out by parent for child:

	YES	NO
1. Has a doctor ever denied or restricted activity for any reason?	___	___
2. Is there an ongoing medical condition (like diabetes, asthma)?	___	___
3. Taking any prescription or nonprescription medicines or pills?	___	___
4. Any allergies to medicines, foods, pollen, or stinging insects?	___	___
5. Ever passed out or nearly passed out DURING exercise?	___	___
6. Ever passed out or nearly passed out AFTER exercise?	___	___
7. Ever had discomfort, pain or pressure in chest during exercise?	___	___
8. Ever been told by a doctor you have __ High blood pressure __ High cholesterol __ A heart murmur __ A heart infection		
9. Does heart race or skip beats during exercise?	___	___
10. Has a doctor ever ordered a test for the heart (ECG, echocardiogram)?	___	___
11. Ever had surgery?	___	___
12. Ever broken or fractured a bone or dislocated a joint?	___	___
13. Ever had a severe sprain, muscle or ligament tear, or tendonitis?	___	___
14. Ever had a bone or joint injury requiring X-rays, MRI, CT surgery, injections, rehabilitation, physical therapy, a brace, cast or crutches?	___	___
15. Ever had a head injury or concussion?	___	___
16. Ever had a seizure?	___	___
17. Ever had vision problems?	___	___
18. Are glasses worn?	___	___
19. Has a change in weight or eating habits been recommended?	___	___
20. Are there speech problems?	___	___
21. Are there emotional problems?	___	___
22. If so, is there a physician or counselor involved?	___	___

Explain "YES" answers here: _____

_____

_____

Parent Signature_____

These answers are true and complete to the best of my knowledge.