

SMITHTOWN CENTRAL SCHOOL DISTRICT HEALTH SCREENING FORM

**This form must be completed and signed by a
parent before physical exam can be conducted**

DATE _____ SCHOOL _____
STUDENT'S NAME _____ DATE OF BIRTH _____
ADDRESS _____ PHONE _____ GRADE _____
FAMILY DOCTOR _____ PHONE _____

	YES	NO
HAS ANYONE IN YOUR FAMILY UNDER THE AGE OF 50 DIED SUDDENLY?	☐	☐
HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD, OR NOW HAVE:		
HEART DISEASE	☐	☐
STROKE	☐	☐
CORONARY ARTERY DISEASE	☐	☐
HIGH BLOOD PRESSURE	☐	☐

STUDENT HISTORY

	YES	NO		YES	NO
<u>CARDIOVASCULAR-RESPIRATORY</u>			<u>DIGESTIVE</u>		
<u>HAS YOUR CHILD HAD OR NOW HAVE:</u>			<u>HAS YOUR CHILD HAD OR NOW HAVE:</u>		
HEART OR LUNG TROUBLE	☐	☐	ANY DIGESTIVE DISORDER	☐	☐
MURMUR HEARD BY A PHYSICIAN AT ANY TIME	☐	☐	IF YES, TYPE AND DATE _____	☐	☐
HIGH BLOOD PRESSURE	☐	☐	<u>NEUROLOGICAL</u>		
CHEST PAINS WITH EXERCISE	☐	☐	<u>HAS YOUR CHILD HAD OR NOW HAVE:</u>		
DIZZINESS OR FAINTNESS WITH WITH EXERCISE	☐	☐	CONCUSSION DATE _____	☐	☐
PALPITATIONS	☐	☐	FAINTING SPELLS	☐	☐
RAPID OR IRREGULAR HEART BEATS	☐	☐	SKULL FRACTURE	☐	☐
WHEEZING WITH EXERCISE	☐	☐	RECURRING SEVERE HEADACHES	☐	☐
RHEUMATIC FEVER	☐	☐	CONVULSIONS OR EPILEPSY	☐	☐
HEART OR LUNG X-RAYS FOR ANY REASON	☐	☐	<u>EYES</u>		
ELECTROCARDIOGRAM FOR ANY REASON	☐	☐	<u>HAS YOUR CHILD HAD OR NOW HAVE:</u>		
<u>BLOOD</u>			<u>EARS/NOSE/THROAT</u>		
<u>HAS YOUR CHILD HAD OR NOW HAVE</u>			<u>HAS YOUR CHILD HAD OR NOW HAVE:</u>		
TENDENCY TO BLEED OR BRUISE EASILY	☐	☐	HEARING LOSS	☐	☐
ANEMIA	☐	☐	CHRONIC SINUS INFECTION	☐	☐
HEPATITIS	☐	☐	FREQUENT NOSE BLEEDS	☐	☐
MONONUCLEOSIS DATE _____	☐	☐	BROKEN NOSE DATE _____	☐	☐

DATE_____

STUDENT'S NAME _____ DATE OF BIRTH _____

	YES	NO
<u>GENITO-URINARY</u>		
HAS YOUR CHILD HAD OR NOW HAVE:		
HERNIA	☐	☐
BLOOD, PUS, OR PROTEIN IN URINE	☐	☐
IMPAIRED FUNCTION OR LOSS OF A KIDNEY	☐	☐
ABSENCE OF TESTICLE	☐	☐
AGE AT ONSET OF MENSTRUATION _____		

	YES	NO
<u>ORTHOPEDIC</u>		
HAS YOUR CHILD HAD OR NOW HAVE:		
BONE FRACTURE DATE _____ AREA _____	☐	☐
JOINT DISLOCATION DATE _____ AREA _____	☐	☐
SPINE OR LIMB DEFORMITY	☐	☐
NECK INJURY	☐	☐
BACK INJURY	☐	☐
KNEE INJURY	☐	☐
ANKLE INJURY	☐	☐
OTHER JOINT PROBLEMS	☐	☐

<u>OTHER</u>		
MY CHILD HAS ORTHODONTIC APPLIANCES AND HAS MY PERMISSION TO FULLY PARTICIPATE IN SPORTS	☐	☐

	YES	NO
<u>ALLERGY</u>		
HAS YOUR CHILD HAD OR NOW HAVE:		
ASTHMA	☐	☐
SEVERE ALLERGY	☐	☐
REQUIRES EPI-PEN	☐	☐
<u>DOES YOUR CHILD:</u>		
TAKE ANY MEDICATION REGULARLY IF YES, NAME _____	☐	☐
TAKE MEDICATION FOR EMERGENCY USE IF YES, TYPE AND DATE _____		
<u>HAS YOUR CHILD:</u>		
EVER HAD AN OPERATION IF YES, DESCRIBE & GIVE DATE _____	☐	☐
EVER BEEN HOSPITALIZED		
IF YES, DESCRIBE & GIVE DATE _____	☐	☐
EVER BEEN TOLD TO GIVE UP ATHLETICS BECAUSE OF A HEALTH PROBLEM IF YES, DESCRIBE _____		
EVER BEEN DIAGNOSED AS HAVING A CHRONIC, ONGOING DISEASE		

IF THERE ARE ANY YES ANSWERS TO THE ABOVE QUESTIONS THAT NEED FURTHER EXPLANATION, USE THIS SPACE:

Signature _____ Date _____
Parent or Guardian