WEBSTER CENTRAL SCHOOL DISTRICT
STUDENT HEALTH HISTORY

TO BE FILLED IN BY PARENT/GUARDIAN AND ATTACHED TO THE HEALTH APPRAISAL FORM:

(Please Print) School ______________________________ Gender_______ Grade________

Student Name______________________________ Birthdate_____________ Birthplace______________

Mother's Name______________________________ _______________/_______________
Primary Phone Secondary Phone

Father's Name ______________________________ _______________/_______________
Primary Phone Secondary Phone

Physician's Name______________________________ Physician's Phone________________

Dentist's Name______________________________ Dentist's Phone__________________

IF YES TO ANY OF THE FOLLOWING QUESTIONS, EXPLAIN BY NUMBER & GIVE DATE OF OCCURRENCE:

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Question	
1. Any known allergies to foods, bee/insect stings, latex, medicines, etc.? ● Describe reaction: (local swelling, hives, face swelling) ● Are emergency meds required? **Yes No**	Yes No
2. Sustained any injury or illness which required medical attention and/or hospitalization or surgery? ● If YES your child may need to be cleared with an MD note to participate in sports/gym.	Yes No
3. Is your child under a physician's care now for any existing problem?	Yes No
4. Absence or loss of function for eye, kidney, testicle, or other organ?	Yes No
5. Requires any ongoing medication at home or school? List above	Yes No
6. Has asthma? ● Are emergency meds required? **Yes No**	Yes No
7. Had a convulsion, seizures, concussion, or loss of consciousness?	Yes No
8. Has diabetes?	Yes No
9. Has recurrent headaches? Explain above (frequency, intensity, any medication)	Yes No
10. Complained of chest pain or fainting during physical exertion?	Yes No
11. Has heart disease, murmur, or irregular heartbeat?	Yes No
12. Wears Orthodontic braces? ● If YES is a specialized mouthpiece from an orthodontist required for sports/PE? **Yes No**	Yes No
13. Had any teeth capped or replaced artificially?	Yes No
14. Wears Glasses? ● For Sports? **Yes No** ● If YES, are glasses impact resistant?----**Yes No** ● Contact lenses? **Yes No** If YES, **How long**?	Yes No
15. Wears Hearing Aid Devices? **Type**	Yes No
16. Is there any medical condition or restriction which may be made worse by playing sports/PE?	Yes No
17. Required by MD to wear brace/support device to play sports/PE?	Yes No

I certify that the above information is true and accurate and understand that it will be relied upon by the Webster Central School District. If medication is prescribed (only valid for current school year) on the health appraisal on reverse side, I authorize the school nurse to administer the prescribed medication as directed by health care provider. I authorize the school nurse to contact the health care provider regarding information on this health appraisal form on reverse side for one calendar year from the date I signed below.

Parent/Legal Guardian Signature______________________________ **Date**_____________

Parent/Guardian Name (print)______________________________ **Relationship**___________