USAX Student Health History Form

Student's name:	☐ **Male** ☐ **Female**	**Birth date:**

List all medicines and other supplements the student is currently taking and planning to bring – English name / dosage / times per day:

1

2

3

Does the student have allergies? ☐ **NO** ☐ **YES – List specific allergy and reaction**

☐ Medicines

☐ pollens

☐ food

☐ stinging insects

☐ Other:

Describe why the student misses school when sick – how often does this happen?

What over-the-counter medications can the student be given?

☐ Aspirin ☐ Tylenol ☐ Pepto-Bismol ☐ Imodium

☐ Other:

Will the student be brining any medications from home – if yes, all containers must be labeled in English or will otherwise be discarded.

Health history questions:	**Explanation of yes answers:**
General health: has the student....	
1. Any ongoing medical conditions?	☐ NO ☐ YES:
Asthma	☐ NO ☐ YES:
Anemia	☐ NO ☐ YES:
Diabetes	☐ NO ☐ YES:
Infection	☐ NO ☐ YES:
Other:	☐ NO ☐ YES:
2. Ever been hospitalized?	☐ NO ☐ YES:
3. Ever had surgery?	☐ NO ☐ YES:
4. Ever had a seizure?	☐ NO ☐ YES:
5. Ever become ill while exercising?	☐ NO ☐ YES:
6. Had frequent muscle cramps while exercising?	☐ NO ☐ YES:
7. Passed out during/after exercise	☐ NO ☐ YES:
Head/neck/spine: has the student....	
8. Had dizziness or headaches with exercise?	☐ NO ☐ YES:
9. Ever had a head injury or concussion?	☐ NO ☐ YES:
10. Had memory problems due to blow to the head?	☐ NO ☐ YES:
11. Had numbness, tingling, weakness after falling?	☐ NO ☐ YES:
12. Been unable to move arm/leg after falling?	☐ NO ☐ YES:
13. Been told he/she has scoliosis?	☐ NO ☐ YES:
14. Had any vision problems/eye injuries?	☐ NO ☐ YES:
15. Been prescribed glasses or contact lenses?	☐ NO ☐ YES:
Heart/lungs: has the student....	
16. Had pain or tightness in chest during exercise?	☐ NO ☐ YES:
17. Felt heart race or skip beats during exercise?	☐ NO ☐ YES:

18.	Ever been told to have a heart test or ecg?	☐ NO ☐ YES:
19.	Had a cough, wheeze, difficulty breathing, shortness of breath during/after exercise?	☐ NO ☐ YES:
20.	Used an inhaler or taken asthma medicine?	☐ NO ☐ YES:
21.	Ever been diagnosed with a heart problem?	
	Heart murmur	☐ NO ☐ YES:
	Heart infection	☐ NO ☐ YES:
	High blood pressure	☐ NO ☐ YES:
	High cholesterol	☐ NO ☐ YES:
	Other:	☐ NO ☐ YES:
	Bone/joint has the student….	
22.	Ever had:	
	Sprain	☐ NO ☐ YES:
	Broken or fractured bone?	☐ NO ☐ YES:
	Stress fracture?	☐ NO ☐ YES:
	Dislocated joint	☐ NO ☐ YES:
23.	Had an injury to a muscle, ligament or tendon?	☐ NO ☐ YES:
24.	Had an injury requiring cast, braces, crutches?	☐ NO ☐ YES:
25.	Needed an x-ray, mri, ct-scan, therapy due to injury?	☐ NO ☐ YES:
26.	Had painful, swollen, feel-warm joints	☐ NO ☐ YES:
	Skin: has the student….	
27.	Had any rashes, pressure sores, skin problems?	☐ NO ☐ YES:
28.	Ever had herpes or a mrsa skin infection?	☐ NO ☐ YES:
	Genitourinary: has the student….	
29.	Had groin pain, bulge or hernia in the groin area?	☐ NO ☐ YES:
30.	Had a urinary tract infection or bedwetting?	☐ NO ☐ YES:
31.	Females only:	
	Had a menstrual period/how many last 12 months?	☐ NO ☐ YES:
	Been pregnant?	☐ NO ☐ YES:
	Dental: has the student….	
32.	Seen a dentist within the past 6 months?	☐ NO ☐ YES:
33.	Had any pain or problems with gums or teeth?	☐ NO ☐ YES:
	Social/learning: has the student….	
34.	Been diagnosed with:	
	Learning disability?	☐ NO ☐ YES:
	Intellectual/developmental disability?	☐ NO ☐ YES:
	Cognitive delay?	☐ NO ☐ YES:
	Add/adhd, etc.?	☐ NO ☐ YES:
35.	Experienced bullying behavior?	☐ NO ☐ YES:
36.	Experienced major grief, trauma, life event?	☐ NO ☐ YES:
37.	Experienced anxiety, fears, phobias	☐ NO ☐ YES:
37.	Exhibited any significant changes in:	
	Behavior?	☐ NO ☐ YES:
	Social relationships?	☐ NO ☐ YES:
	Grades?	☐ NO ☐ YES:
	Eating habits?	☐ NO ☐ YES:
	Sleeping habits?	☐ NO ☐ YES:
	Withdrawn from family/friends?	☐ NO ☐ YES:

38. Been worried, sad, upset, angry much of the time?	☐ NO	☐ YES:
39. Shown loss of energy, motivation, interest?	☐ NO	☐ YES:
40. Had concerns about weight – trying to gain/lose?	☐ NO	☐ YES:
41. Any history of substance abuse		
Used/uses tobacco?	☐ NO	☐ YES:
Used/uses alcohol?	☐ NO	☐ YES:
Used/uses other drugs?	☐ NO	☐ YES:
Any history of self-abuse, attempted suicide?	☐ NO	☐ YES:
Family health: in the student's family....		
42. Is there a family history of:		
Anemia/blood disorders?	☐ NO	☐ YES:
Asthma/lung problems?	☐ NO	☐ YES:
Behavioral health issues?	☐ NO	☐ YES:
Diabetes?	☐ NO	☐ YES:
Inherited disease:	☐ NO	☐ YES:
Kidney problems?	☐ NO	☐ YES:
Seizure disorder?	☐ NO	☐ YES:
Sickle cell trait or disease?	☐ NO	☐ YES:
43. Is there a family history of heart-related problems:		
Brugada syndrome?	☐ NO	☐ YES:
Cardiomyopathy?	☐ NO	☐ YES:
High blood pressure?	☐ NO	☐ YES:
High cholesterol?	☐ NO	☐ YES:
Qt syndrome?	☐ NO	☐ YES:
Marfan syndrome?	☐ NO	☐ YES:
Ventricle tachycardia?	☐ NO	☐ YES:
Other:	☐ NO	☐ YES:
44. Unexplained fainting, seizures, drowning?	☐ NO	☐ YES:
45. Death from heart problems before age 50?	☐ NO	☐ YES:
Sports: has the student....		
46. Ever been told by a doctor not to play any sport?	☐ NO	☐ YES:

I/we, the student and his/her parents, understand that the information provided in this document will be used to purchase health insurance on behalf of the student. Providing false or misleading information to an insurance company is a serious crime in the United States which can result in the termination of insurance coverage, liability for medical expenses and possibly prison time. Additionally, the information contained herein might be shared in order to permit the student to play school sports or engage in other strenuous activities. I/we confirm that all of the information provided is true, full and complete to the best of my/our knowledge and give consent for an exchange of health information between the agency, school nurse and healthcare providers.

Signature of the student Date

Signature of the student's father Date

Signature of the student's mother Date


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