Smithtown Central School District
Health Screening Form

It is the sole responsibility of the parent and/or guardian to furnish the Health Office with information regarding any change in the health status.

Name:_____ **DOB:**___/___/____ **Grade:**_____

Parent/Guardian: Answer the following questions as accurately as possible with details if needed.

1. Has student suffered any head injuries/concussions with or without loss of consciousness during his/her lifetime Yes/ No When?_____Did loss of consciousness occur? Yes/ No
Describe event_____
_____

2. Any broken bones, fractures, surgery? Yes/ No When?_____
Describe_____

3. Any other injury requiring medical attention/hospital visit? Yes/ No When?_____
Describe_____

4. History of heart murmur? Cardiac Arrhythmia? Palpitations? Yes/ No Describe_____
_____

5. Asthmatic? Yes/ No Requires an inhaler for sports/exercise? Yes/ No Describe_____
_____

6. Any other chronic diseases or ailments? Yes/ No Describe_____
_____

7. Any fainting/ dizziness/fatigue after exertion? Yes/ No Describe_____
_____

8. Taking Medications at this time? Yes/ No Describe_____
9. Allergies? Yes/ No Describe_____

10. Glasses/contact lenses: Yes/ No Protective eyewear needed? Yes/ No
Orthodontic appliance? Yes /No
11. Any other conditions that the health office should be aware of? Yes/ No Describe_____
_____

Parent or Guardian signature:_____ Date:_____

H-22 6/17