

GREAT NECK PUBLIC SCHOOLS

Health Services

“A” Form

HEALTH HISTORY – TO BE COMPLETED BY PARENT AND CHILD

“A” Form / Side 1

Name _____ Sex _____ Age _____ Date of Birth _____

Grade _____ School _____

It is recommended that all students see their own health care provider for this examination, which can be coordinated with general preventative care including health assessment, counseling and immunizations. If you are unable to have this examination done with your own health care provider, it will be done by the district medical staff.

If your child is to be evaluated by the district physicians, please note the following:

1. The history checklist must be reviewed and co-signed by a parent or guardian.
2. Girls will be examined wearing shorts and tank tops to facilitate a musculoskeletal and scoliosis examination.
3. Boys will be examined wearing shorts and no shirt to facilitate musculoskeletal and scoliosis examinations.
4. Boys must have a testicular examination. There is no need to have breast or genital examinations on girls.

Explain “Yes” answers below.

Circle questions you don’t know the answers to

	Yes	No		Yes	No
1. Have you had a medical illness or injury since last check up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you cough, wheeze, or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you use any special protective or corrective equipment or devices that aren’t usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or Nonprescription (over-the-counter) medications or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain, or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you have kidney disease or one kidney?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	MALES ONLY		
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you have an undescended testicle?	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY		
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	17. When was your first menstrual period? _____		
7. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	When was your most recent period? _____		
Have you ever been knocked out, become unconscious, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	How many periods have you had in the last year? _____		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	Are your periods regular? _____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Explain “Yes” answers here: _____		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Have you ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

I hereby state that, to the best of my knowledge, answers to the above questions are complete and correct.

PARENT/GUARDIAN SIGNATURE _____ DATE _____
(REQUIRED)

**Health Services
"A" Form**

To Be Completed by Physician

"A" Form / Side 2

Student's Name _____			
Last	First	Middle	Sex
Date of Birth: _____	Height: _____	Weight: _____	Pulse: _____ Blood Pressure: _____
Vision: R 20/ _____	L 20/ _____	Corrected: Yes _____ No _____	Pupils: Equal _____ Unequal _____

***Please attach current immunization record**

	NORMAL	ABNORMAL FINDINGS		NORMAL	ABNORMAL FINDINGS
Appearance			Musculoskeletal		
Eyes /Ears Nose/Throat			Neck		
Lymph Nodes			Back / Scoliosis		
Heart			Shoulder / Arms		
Pulses			Elbow / Forearm		
Lungs			Wrist / Hand		
Abdomen			Hip / Thigh		
Genitalia (males)			Knee		
Skin			Leg / Ankle		

Body Mass Index: _____ · _____
 Weight Status Category (BMI Percentile)
 less than 5th 5th through 49th 50th through 84th 85th through 94th 95th through 98th 99th & Higher

Specify Current Diseases: Asthma Diabetes Type 1 Diabetes Type 2 Hyperlipidemia Hypertension
 Other _____

- CLEARED:** I have reviewed Side 1 and Side 2 of this form with parent & child. Student is cleared for Interscholastic Sport Participation (if appropriate) and All School Activities.
- CLEARED:** After completing Rehabilitation/Evaluation for _____
- NOT CLEARED FOR:** _____ **REASON:** _____

Recommendations: _____

Physician's Name (Print/Stamp) _____ Phone # _____
 Address _____ City _____ State _____ Zip _____

Signature of Physician _____ **MD or DO or NP EXAM DATE (Mo/Day/Yr)** _____

 SCHOOL DOCTOR _ COSIGN _____ Date _____