

WARREN TOWNSHIP SCHOOLS

Yearly **Updated** Health History

Student's Name _____ Gr: _____

Date of Birth _____ Age _____

Telephone _____ Address _____

Please explain responses on back –Update from Past Year ONLY

	yes	no
1.Has been medically advised not to participate in any sport, and the reason for such		
2.Is under a physician's care and the reason for such care		
3.Has experienced loss of consciousness after an injury		
4.Has experienced a fracture or dislocation		
5.Has undergone any surgery		
6.Takes medication on daily basis: name and reasons		
7. Has allergies: Including hives, asthma, reactions to bee stings, or food allergies- medication used?		
8.Has experienced frequent chest pains or palpitations		
9.Has a recent history of fatigue or undue tiredness		
10.Has a history of fainting with exercise		
11.Has a history of family member having sudden death		
12.Has a bleeding tendency		
13.Has had rheumatic fever		
14.Has a vision defect: wears glasses, wears contacts		
15.Has a loss or seriously impaired function of a paired organ (eye, ear, testicle, kidney)		
16.Has had a dental checkup by a dentist within the year		
17.If the child had a dental checkup, did the child have cavities		

Parent/Guardian Signature

Date