

Required at time of registration

Student Immunization Record

**Jericho Union Free School District
STUDENT HEALTH HISTORY & UPDATE**

NAME _____ D.O.B. _____ GRADE IN SEPT. _____

Please check if the student has ever had any of the following:

_____ Anemia	_____ Headaches	_____ Tuberculosis
_____ Asthma Allergies	_____ High Blood Pressure	_____ Jaundice
_____ Diabetes	_____ Heart Disease Murmur	_____ Seizures
_____ Chronic Cough	_____ Eye Problem	_____ Hearing Loss
_____ Kidney Disease	_____ Rheumatic Fever Joint Problem	_____ Stomach Pain
_____ Prolonged Bleeding		

Give dates and explanations for any conditions checked above _____

SINCE THE LAST PHYSICAL EXAMINATION HAS YOUR CHILD HAD ANY OF THE FOLLOWING?

	YES	NO
1. Any injuries requiring medical attention?	_____	_____
2. Any illness lasting more than 5 days?	_____	_____
3. Taking any medications/under physician's care?	_____	_____
4. Any feeling of faintness, dizziness, or fatigue after heavy exertion?	_____	_____
5. Wears glasses, contacts?	_____	_____
6. A surgical procedure/fracture?	_____	_____
7. Treatment in a hospital or emergency room?	_____	_____
8. Any reason this person should not participate in any sport?	_____	_____
9. Any excused absences from Phys. Ed.?	_____	_____
10. Any known allergies?	_____	_____
11. Any chronic disease?	_____	_____
12. Any head injury with or without loss of consciousness ?	_____	_____

If you answer "YES" to any of the above questions, please explain the reason below

COMMENTS: _____

PARENT/STUDENT INFORMATION

Student Name: _____ D.O.B. _____ Sex _____

Parent/Guardian: _____ Phone #: _____

Home Address: _____ Alternate #: _____

Parent/Guardian Signature _____

Date _____