

**Medical History Questionnaire
TO BE COMPLETED BY PARENT**

STUDENT'S NAME _____ Grade _____ DOB _____
(If you answer yes to any of the following questions please provide an explanation on the back of the page.)

- | | YES | NO |
|---|--------------------------|--------------------------|
| Does your child have any significant medical history? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your child currently under treatment by a physician for any active medical problem? If you answered YES, please explain. _____ | | |
| Does your child have a single <i>paired</i> organ(s) e.g. kidney, testicle, vision one eye | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child ever been hospitalized? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child ever had surgery? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child take medication regularly? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, medication and reason _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child have any allergies to foods, insects and/or environmental? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | |
| Has your child ever been diagnosed with a concussion? | <input type="checkbox"/> | <input type="checkbox"/> |

IF YOU ANSWER YES TO QUESTIONS # 1 and/or # 2 BELOW, YOUR CHILD MUST RECEIVE CARDIAC CLEARANCE

- | | | |
|---|-----|-----|
| 1. Does your CHILD have a history of any of the following | () | () |
| • Unexplained fainting or near fainting | () | () |
| • Chest pain/discomfort on exertion | () | () |
| • Excessive and unexplained fatigue associated with exercise | () | () |
| • Heart murmur (other than innocent murmur) | () | () |
| • High blood Pressure | () | () |
| 2. Is there a FAMILY history of any of the following? | | |
| • One or more relatives who died of heart disease (sudden/unexpected or otherwise) before age 50 | () | () |
| • Close relative under age 50 with disability from heart disease. | () | () |
| • Specific knowledge of certain cardiac conditions in family members including hypertrophic or dilated cardiomyopathy | () | () |
| • Long QT syndrome, Marfan syndrome or clinically important arrhythmias | () | () |

Are there any other information or health concerns that the school should be aware of in order to safeguard your child's health? (Please explain). _____

I understand that this confidential information will be shared with the school personnel deemed appropriate by the health professional in my child's building.

Parent/Guardian Signature: _____

Date: _____