HEALTH HISTORY FORM
Middlesex School Health Center

Name:_____DOB:_____Grade:_____
Name of person filling out this form:_____Relationship to student:_____
(Please note, student must be at least 18 years old to complete this form.)
Emergency contact, in case a parent or guardian is unavailable:
Name_____Relationship:_____Number_____
Student cell phone number:_____

Allergies: **Specific items allergic to:** **Result of exposure:** **Prescribed Epinephrine?:**
Food_____
Insect/Stings_____
Drugs/Medications_____
Environment_____
Skin Irritants_____

Medical Conditions and Past Injuries: Please check off all injuries that apply.
Head:

- ☐ Black outs ☐ Loss of Consciousness ☐ Memory Loss ☐ Skull Fracture
- ☐ Neck injury ☐ Seizures ☐ Dizziness ☐ Fainting
- ☐ Headaches (type?)_____
- ☐ Concussion (please indicate how many and dates)_____

Muscular/Skeletal:

- ☐ Fractures (where/when?)_____
- ☐ Sprains/strains (where/when?)_____
- ☐ Dislocations (where/when?)_____

Other injuries_____
Previous surgeries_____

Cardiopulmonary:

- ☐ Asthma ☐ Shortness of breath (when?)_____
- ☐ Irregular heart beat ☐ Skipped heart beats ☐ Murmurs
- ☐ Chest pain ☐ High blood pressure ☐ Low blood pressure

Endocrine:

- ☐ Diabetes ☐ Thyroid issues
- ☐ Menstrual issues (age of onset, regularity, bleeding difficulties, pain, any treatments):_____
  _____

Mental Health History (i.e. depression, eating disorders, anxiety, sleep disorders, counseling other treatments):
_____
_____

Communicable Diseases (provide dates)

☐ Mononucleosis ☐ Hepatitis ☐ MRSA

Previous hospitalizations? (For what? When?)

Is there any medical or psychological condition for which the student is currently under a physician's care?

Does the student wear any special braces, contact lenses, glasses, dentures/bridges?

Has the student been diagnosed with sickle cell disease or trait? ☐ No ☐ Yes (disease or trait?)

Is there any field of athletics in which you FORBID PARTICIPATION? ☐ No ☐ Yes, Explain

Has the student been advised by a medical provider to restrict activity within the past 5 years?
For What?_____ When?_____ For how long_____

MEDICATIONS:
Please list any current medication the student taking

Please read the Health Center Medication Policy and include a Prescription Medication Order Form for each prescription filled out by the prescriber.

FAMILY HISTORY/INFORMATION

	Name in Full	Age	Occupation	State of Health
Father				
Mother				
Siblings				

If a close family member is not living, please state cause of death, age, year of occurrence

If parents are divorced, separated or remarried, please indicate (with dates):

Has anyone in the family died of heart problems or sudden death before age 40? ☐ Yes ☐ No
If yes, Explain:_____

All information on this form is true and accurate. I understand that all health center forms including an updated annual physical examination must be on file to register and participate in athletics.

Parent/Guardian signature_____ Date_____ *Rev: 4/18*