Baldwinsville Central School District
Build - Educate - Empower

Student Health History Report

Name:	**Affirmed Name** (if applicable):	**DOB:**
Sex Assigned at Birth: ☐ Female ☐ Male	**Gender Identity:** ☐ Female ☐ Male ☐ Nonbinary	

Primary Care Provider: _____ **Date of last physical:** _____
Please list other Medical Provider(s) student regularly follows up with: _____

Diagnosed with Allergies? ☐ yes ☐ no	• If YES, please list all allergies:
Diagnosed with Asthma? ☐ yes ☐ no	• If YES, ☐ Intermittent ☐ Persistent ☐ Other:
Diagnosed with Seizures? ☐ yes ☐ no	• If YES, date of last seizure: • Type of seizure(s):
Diagnosed with Diabetes? ☐ yes ☐ no	• Type: ☐ 1 ☐ 2 If YES, age diagnosed?
On daily Medication(s)? ☐ yes ☐ no	• If YES, will your student require medication(s) at school? ☐ yes ☐ no • Please list medications required at school: _____ • Name of medication(s) taken at home? _____

Are there any health restrictions? If YES, please explain:

Please list any hospitalizations and/or operations with dates:

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

Anemia	□ Anxiety	□ Cardiac Issues or family history	□ Concussion: Date:
Dental Problems	□ Depression	□ Difficulty Sleeping	□ Eczema
Encopresis (soiling)	□ Enuresis (wetting)	□ Fractures (Broken Bones)	□ Frequent Ear Infection
Glasses/Contacts	□ Hearing Problems/Device	□ Kidney Disease	□ Lead Poisoning
Serious Injury	□ Temper Tantrums	□ Urinary Tract Infections	

If YES, explain here: _____

Special Clinics Student Has Attended (check any that apply)
□ Hearing □ Speech □ Mental Health □ Orthopedic □ Cardiac/Heart

Parent/Guardian Signature:_____ Date:_____