Year 2018-2019

CiTi BOCES

Center for Instruction Technology and Innovation

Nursing Assistant Program

HEALTH HISTORY

Student's Name_____ DOB_____ Age_____

Address_____ School District_____

_____ Home Phone Number_____

Have you had or do you have now any of the following: (Mark **X** if yes)

( )	Asthma	( )	High or low blood pressure
( )	Back problems	( )	Infectious mononucleosis
( )	Blood disease / clots	( )	Kidney disease
( )	Bloody bowel movements	( )	Low blood sugar
( )	Cancer	( )	Menstrual problems
( )	Chest pain	( )	Nervous/Anxiety disorder
( )	Coughing / spitting blood	( )	Painful joints
( )	Diabetes	( )	Physical limitations on lifting*
( )	Eye disease	( )	Skin disease
( )	Fainting / dizziness	( )	Seizures / convulsions
( )	Fractures / dislocations	( )	Stroke
( )	Headaches / migraines	( )	Thyroid
( )	Hearing	( )	Tuberculosis
( )	Hernia	( )	Ulcers
( )	Heart murmur	( )	Urinary tract infections
( )	Hemophilia / Bleeding Disorder	( )	Vision: ___contact lenses___glasses
( )	Hepatitis / jaundice	( )	Other conditions_____

*If physical limitations on lifting checked, must have note from medical provider attached

Please explain any of the areas checked above:_____

_____

_____

_____

_____

Allergies (foods, drugs or environmental):_____

Reaction that occurs:_____

Do you have an epi-pen: ☐ **yes or** ☐ **no**

Do you take any medications during the school day? □ **yes or** □ **no**

If checked yes, please list name of medication(s)_____

The information on this history form is accurate and to the best of my/our knowledge.

Student signature_____ Date_____

Parent/Guardian Signature_____Date_____