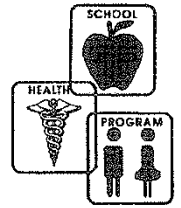




**Family Health Network of Central New York, Inc.
School Health Program**



HEALTH HISTORY UPDATE

Student's Name _____ **Date of Birth** _____ **Grade** _____

To better understand your son's/daughter's total health, it would be helpful for us to know the following information. (Circle appropriate answer and explain as needed)

RECENT HEALTH

- No Yes** 1. Has your son/daughter had an illness that needed close watching or prolonged treatment by an outside provider?
If **Yes**, please explain: _____
- No Yes** 2. Has your son/daughter seen a specialist? (Bone doctor, ear, nose throat doctor etc?)
If **Yes**, whom? _____ Are they still under treatment? **No Yes**
- No Yes** 3. Has your son/daughter been seen in the Emergency Room, Doctor's or Clinic? (e.g. for serious injury, surgery, illness?) If **Yes**, for what reason: _____
When: _____ Where: _____
- No Yes** 4. Is your son/daughter presently under the care of another health care provider (doctor, nurse practitioner, chiropractor)? If **Yes**, please explain: _____
- No Yes** 5. Is your son/daughter presently taking any medications?
If **Yes**, please list medication name, dose, and who prescribes _____
How often? _____
For how long? _____
- No Yes** 6. Do you have any health concerns regarding your son/daughter we should be aware of?
If **Yes**, please explain: _____
- No Yes** 7. Has your son/daughter been to the dentist? Last visit date? _____

TUBERCULOSIS RISK ASSESSMENT SCREENING TOOL

Please circle one answer for each question. Has your child had a:

- No Yes** 1. TB screening test? Result positive or negative? _____
- No Yes** 2. Known exposure to adults who are HIV positive, user of IV or street drugs, homeless, residents of nursing homes, migrant workers or adults with infectious tuberculosis?
- No Yes** 3. Lived in, visited, or had close contact with someone who visited or lived in a region with a high incidence of tuberculosis? (with an unknown skin test status)
- No Yes** 4. Had an abnormal chest x-ray suggestive of TB?
- No Yes** 5. Been found to be HIV positive?
- No Yes** 6. Been in prison or in close contact with someone who has been in prison within the last five years?
- No Yes** 7. Has this child spent more than 30 consecutive days outside the US? If yes, where _____? When _____?

LEAD TESTING RISK ASSESSMENT SCREENING TOOL

Please circle one answer for each question.

- No Yes** 1. Do you live in and/or regularly visit a house or child care facility built before 1950?
- No Yes** 2. Do you live in a house built before 1978 that is undergoing renovations or has chipping/peeling paint?
- No Yes** 3. Does this child have a brother or sister, housemate, or playmate being followed or ever treated for lead poisoning?
- No Yes** 4. Does this child frequently come in contact with an adult who has a job or hobby that involves exposure to lead? (e.g. house painting, construction, welding, battery recycling, lead smelting, jewelry or pottery making)
- No Yes** 5. Does your family use traditional medicine, health remedies, cosmetics, powders, spices, or foods from other countries? (e.g. alkohl, azarcon, bala goli, ghasard, greta, pay-loo-ah, DawTway, DawKyin, dhavana, or shakti)
- No Yes** 6. Does this child eat non-food items (pica)? Does your child put things in their mouth such as toys, jewelry, or keys?
- No Yes** 7. Does your family cook, store, or serve food in lead, crystal, pewter, or pottery from Asia or Latin America?
- No Yes** 8. Have you lived in or spent time ≥ 2 months in an area outside of the USA?

FAMILY HISTORY

Check all applicable illnesses/diseases for each family member:

Family Member	Asthma	Diabetes	Cancer	Heart Disease	Hypertension	Genetic Disease	Hepatitis B	Hepatitis C	Mental Illness	Seizures	HIV	Tuberculosis	Alcohol/Drug Abuse	Anxiety	Depression	ADD/ADHD	Age at Death	If deceased, cause of death
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandmother (mother's mother)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandfather (mother's father)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Grandmother (father's mother)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Grandfather (father's father)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mother's brother/sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Father's brother/sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brother/Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____																		

Parent's name: _____ Date: _____

Phone number: Daytime _____ Home: _____

Please feel free to contact us at any time to discuss your concerns.
The Staff at the School Health Program

Cincinnatus Central School
2809 Cincinnatus Road
Cincinnatus, NY 13040
(607) 863-3200 x2 x2

DeRuyter Central School
711 Railroad Street
DeRuyter, NY 13052
(315) 852-3400 x8

Appleby Elementary School
P.O. Box 339
Marathon, NY 13803
(607) 849-3180

Marathon High School
P.O. Box 339
Marathon, NY 13803
(607) 849-3900