Arlington School – 115 Mill Street, MS 111, Belmont, MA 02478 – (617) 855-2124

Student Health Screening Form

Student Name _____ **DOB** _____

In combination with the most recent record of your child's **Physical Exam, Immunization Records** and **Dental Exam,** please complete the following checklist and supply all documentation to Arlington School's Nurses Office upon enrollment or at the beginning of each school year.

Y	N	
☐	☐	Has your child had a Physical Exam in the past year? Doctor's Name _____ Exam Date _____
☐	☐	Has your child had a Dental Exam in the past year? Dentist's Name _____ Exam Date _____
☐	☐	Does your child see an Orthodontist?
☐	☐	Has your child ever had an allergic reaction? Explain: _____
☐	☐	Has your child ever had an allergic reaction to medication?: Explain: _____
☐	☐	Does your child have a chronic or ongoing illness?: Explain: _____
☐	☐	Has your child ever had surgery?: Explain: _____
☐	☐	Does your child have any physical limitations that may require program modifications and/ /or restrictions? Explain: _____
☐	☐	Has your child ever taken any supplements or vitamins to help gain or lose weight to improve performance?: Explain: _____
☐	☐	Has your child ever experienced a seizure or convulsions?: Explain:
☐	☐	Has your child ever had a head injury or concussion: Explain: _____
☐	☐	Has your child ever been knocked out, lost consciousness, or lost his/her memory?: Explain: _____

Please check all medical conditions that apply:

GENERAL
- ☐ Recent weight loss or gain
- ☐ Heat or cold intolerance
- ☐ Difficulty sleeping

HEAD, EYES, EARS, NOSE, MOUTH, THROAT
- ☐ Headache
- ☐ Dizziness
- ☐ Loss of hair
- ☐ Hearing difficulties
- ☐ Dry mouth
- ☐ Vision, glasses, contacts

RESPIRATORY
- ☐ Asthma
- ☐ Use inhaler

CARDOVASCULAR
- ☐ Irregular heart beat
- ☐ Murmur
- ☐ Palpitations
- ☐ Under a doctor's care

GASTROINTESTINAL
- ☐ Loss of appetite
- ☐ Heartburn, indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Pain or cramps in abdomen
- ☐ Diarrhea
- ☐ Constipation
- ☐ Vomiting blood

SKIN
- ☐ Hives or welts
- ☐ Easy bruising

INFECTIOUS – RECURRENT INFECTIONS
- ☐ Ear
- ☐ Sinus
- ☐ Lung
- ☐ Skin
- ☐ Bone
- ☐ Other: _____

GEMOTPIROMARY
- ☐ Pain with urination
- ☐ Increase in frequency/urgency with urination
- ☐ Blood in urine

FEMALES ONLY
- ☐ Menstrual cycles, started at age: _____
- ☐ Regular cycle
- ☐ Pregnant

MALES ONLY
- ☐ Rash or sores on penis
- ☐ Discharge from penis

BONES, MUSCLES, JOINTS
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Numbness or tingling

NERVOUS SYSTEM
- ☐ Seizures
- ☐ Under a doctor's care
- ☐ On medication

Signature of Parent/Guardian **Date**

Signature of Student if 18 years of age or older **Date**

Should your child have a health condition that is not included on the above list or a condition that has developed throughout the school year, please contact the School Nurse at (617) 855-2124 so we may update our medical information records.