CEDAR HILL PREP SCHOOL

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STUDENT HEALTH QUESTIONNAIRE

To be completed by the parent or guardian. **Please return the Confidential Medical Record & Emergency Card & the Student Health Questionnaire to the Admission Office.**

Family Name ______________________________ First Name ______________________________

Date of Birth ______________________________ Sex ☐ M ☐ F

Medical History	Yes	No	If yes, please explain
Allergies			
Asthma			
Cardiac Disorder			
Diabetes			
Gastrointestinal Disorder			
Hearing Disorder			
Hypertension			
Neuromuscular Disorder			
Orthopaedic Condition			
Respiratory Illness			
Seizure Disorder			
Skin Disorder			
Visual Disorder			
Other (please specify)			

Participation for Sports Questionnaire	Yes	No	If yes, please explain
Is the Student...			
presently taking medication?			
diagnosed with asthma?			
prescribed asthma medication?			
Does the student...			
wear glasses or contact lenses?			
have any known deformalities?			
tire quickly during exercise?			
have frequent severe headaches?			
Has the student...			
ever fainted during or after exercise?			
ever been dizzy or after exercise?			
ever had chest pain during or after exercise?			
ever had racing of their heart or skipped heart beats?			
ever had high blood pressure or high cholesterol?			
ever had told they had a heart mumur?			
ever had a head injury or concussion?			
ever been knocked out or became unconscious?			
ever lost their memory?			
ever had a seizure?			
ever had a numbness or tingling in their arms, hands, legs or feet?			
Has any member of your family died...			
before the age of 50?			
Has anyone in your family had a heart attack...			
before the age of 50?			

I certify that the above information is correct to the best of my knowledge.

______________________________ ______________

Signature of Parent or Guardian Date