

# Compass School Health Form

PO Box 177 Westminster Station, VT 05159 (802) 463-2525

The information in the form is CONFIDENTIAL and not part of the permanent transcript.  
Please complete ALL parts of the form.

Student's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Yes No** 1. Have you ever had or are you being treated for any of the following?

If yes, please circle below.

- |                  |                             |                        |
|------------------|-----------------------------|------------------------|
| ADD/ADHD         | Chronic Cough               | Loss of Eyesight       |
| Allergies        | Concussion                  | Menstrual Cramps       |
| -Medicines       | Depression                  | Mono                   |
| -Bees            | Diabetes                    | Rheumatic Fever        |
| -Foods           | Dizziness/Fainting          | Shortness of Breath    |
| -Pollens         | Eating Problems             | Stomach Pains          |
| -Other (explain) | Headaches (recurring)       | Seizures               |
| Anemia           | Hearing Loss                | Skipped Heartbeats     |
| Anxiety/Worries  | Heart Murmur                | Weight Change (recent) |
| Asthma           | Hepatitis (Yellow Jaundice) | Weakness               |
| Chest Pain       | Hernia                      |                        |
| Chicken Pox      | High Blood Pressure         |                        |

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**Yes No** 2. Have you ever had surgery? If Yes, please explain:

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**Yes No** 3. Have you ever had an injury or illness that prevented you from attending school or playing sports?

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**Yes No** 4. Have you ever felt dizzy or blacked out with hard exercise? \_\_\_\_\_

**Yes No** 5. Have you ever had an injury to any of the following? If yes, circle and explain below.

- |          |      |      |       |
|----------|------|------|-------|
| Neck     | Arm  | Back | Ankle |
| Shoulder | Hand | Knee | Foot  |

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**Yes No** 6. Are you taking any medicines(s) on a regular basis? If yes, please list name, dose and how often.

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**Yes No** 7. Are you allergic to any medicines? If yes, please list.

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**Yes No** 8. Has anyone in your family (grandparents, mother, father, brother or sister)

- had a hearth attack younger than age 50
- had other heart disease diagnosed younger than age 50
- died younger than age 50? If yes, please explain.