



Bristol Township School District

STUDENT HEALTH HISTORY FORM

The Bristol Township School District requests that the parents/guardians of all incoming students complete the following confidential Health History to help the school nurse develop a Care Plan for your child, should your child need medical, physical, emotional, social and/or academic assistance. If you have any questions, please feel free to contact the school nurse.

Student's Name _____ Birth Date _____ Grade _____ Sex _____

Home Address _____ City _____ Zip _____ Home Phone _____

Student Lives with: _____

Parent/Guardian's Name _____ Work# _____ Cell# _____

Parent/Guardian's Name _____ Work# _____ Cell# _____

List all people living in household:

	Name	Sex	Relationship to Student	Occupation or Grade/Age (if sibling)
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Name of last school attended _____ Phone # _____

Address _____ City _____ State _____ Zip _____

The Pennsylvania Department of School Health requires a physical examination in grades K, 6 and 11. They also require a dental examination in grades K, 3 and 7. These examinations are also required for those students with incomplete health records. The examinations will be accepted if completed one year before the school year begins.

*Please indicate below your preference for the completion of the mandated physical and/or dental examinations. If you choose to have your student seen by the school district's dentist or physician, it will be **FREE** and of no cost to you. If you do not provide your child's exam by October 1st of the school year the exam is needed, your child will be scheduled to see our school physician.*



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I prefer our **PRIVATE PHYSICIAN/DENTIST** to do the physical/dental examination.

DATE OF EXAMINATION(S): Physical _____ **Dental** _____

I prefer the **SCHOOL PHYSICIAN** do the physical examination.

I prefer the **SCHOOL DENTIST** to do the dental examination.

If you do not have Health Insurance, Dental Insurance and/or Vision Insurance, contact your school nurse for more information regarding free/low cost dental, vision and health care.

Please check if your student FREQUENTLY experiences any of the following:

Nosebleeds	Diarrhea	Poor sleep patterns	Poor eating patterns
Colds	Stomachaches	Nightmares	Difficulty breathing through nose
Sore throats	Headaches	Stammering/Stuttering	Breathless with activity
Urination	Dental problems	Persistent coughing	Pains in arms/legs
Constipation	Chest pain	Earaches/drainage	Stumbles or drops things

Medical History – Please check all that apply.

ADD/ADHD	Abnormal Blood Lead Levels	Endocrine Disorder	Orthopedic Condition
Anemia	Chemical/Hormonal Imbalance	Fainting Spells	Neurological Disorder
Arthritis	Color Vision Deficit/Blindness	Hay Fever	Psychiatric Condition
Asthma	Connective Tissue Disorder	Heart Disorder	Scoliosis
Bleeding Problem	Developmental Delay	Heart Murmur	Seizure Disorder
Blood Disorder	Drug/Tobacco/Alcohol Usage	Head/Neck Injury	Short Stature
Cancer	Emotional/Behavioral Condition	Hernia	Sickle Cell Anemia
Cerebral Palsy	Joint/Bone/Muscle Problem	High Blood Pressure	Skin Disorder
Cystic Fibrosis	Immunosuppressive Disorder	Kidney Problem	Speech Problems
Dental Condition	Muscular Dystrophy	Liver Problem	Spina Bifida
Diabetes	Neuromuscular Disorder	Lung Condition	Tuberculosis
Dietary Restrictions	Stomach/Intestinal Disorder	Migraine Headaches	Underweight
Eating Disorder	Tourette’s Syndrome	Overweight	Other _____



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Explain condition(s) checked above or any other medical condition(s): _____

Allergies: Food Insect/Bee Medication Plants Animals Seasonal Environmental Other _____
Specify allergy(ies), reaction(s) and treatment(s) _____

Hearing/Ear Problems: Yes No. If yes, type _____ Tubes? Yes No Hearing aide(s)? Yes No

Vision Problems: Yes No. If yes, diagnosis _____ Wears glasses/contacts? Yes No

Recurring illness/infection: Yes No. If yes, explain _____

List major injuries, operations and/or hospitalizations: _____

Does any of the above prevent full participation in any school or physical education program? Yes No

If yes, explain: _____

List medication(s) taken at home regularly _____

List any medication to be taken at school* _____

*physician's orders are required

May the school staff be informed of your student's health history? Yes No

Would you like a conference with the school nurse? Yes No

Parent/Guardian Signature _____ **Date** _____