School District of Bristol Township
Health History

Form#40

School_____ Grade_____ Date_____

Child's Name_____ Sex_____ D.O.B._____

SCHOOL AND DISTRICT LAST ATTENDED_____

CURRENT ADDRESS_____

HOME PHONE_____ CELL_____ E-MAIL_____

MOTHER'S NAME_____ FATHER'S NAME_____

GUARDIAN'S NAME_____

FAMILY PHYSICIAN_____ DR.'S PHONE NUMBER_____

DOES YOUR CHILD HAVE AN I.E.P. OR 504 PLAN?_____

DOES YOUR CHILD HAVE:	YES	NO	HAS YOUR CHILD HAD:	YES	DATE	NO
6 OR MORE COLDS PER YEAR	_____	_____	CHICKENPOX	_____	_____	_____
6 OR MORE SORE THROATS PER YEAR	_____	_____	CONVULSIONS	_____	_____	_____
ASTHMA OR WHEEZING	_____	_____	GERMAN MEASLES	_____	_____	_____
HAY FEVER	_____	_____	MEASLES	_____	_____	_____
CHRONIC COUGH	_____	_____	MUMPS	_____	_____	_____
FREQUENT EAR INFECTIONS	_____	_____	POLIO	_____	_____	_____
HEARING PROBLEMS	_____	_____	RHEUMATIC FEVER	_____	_____	_____
HEARING AID PRESCRIBED	_____	_____	MONO	_____	_____	_____
VISION PROBLEMS	_____	_____	BED WETTING	_____	_____	_____
GLASSES PRESCRIBED	_____	_____	HERNIA	_____	_____	_____
SPEECH DIFFICULTIES	_____	_____	HEPATITIS	_____	_____	_____
POOR POSTURE	_____	_____	APPENDICITIS	_____	_____	_____
EMOTIONAL PROBLEMS	_____	_____	TONSILS REMOVED	_____	_____	_____
EXTREME ACTIVITY OR RESTLESSNESS	_____	_____	TB	_____	_____	_____
DIFFICULTY SLEEPING	_____	_____	WHOOPING COUGH	_____	_____	_____
TEMPER TANTRUMS AFTER AGE 5	_____	_____	FAINTING SPELL	_____	_____	_____
CONCUSSION	_____	_____	HEART MURMUR	_____	_____	_____
FREQUENT FALLS	_____	_____	OTHER_____	_____	_____	_____
FREQUENT STOMACH ACHES	_____	_____	FREQUENT HEADACHES	_____		_____

IS YOUR CHILD ALLERGIC TO ANYTHING?_____ WHAT?_____
TYPE OF REACTION_____
HAS YOUR CHILD HAD ANY OPERATIONS?_____ DATES_____
TYPE OF OPERATIONS_____
ANY OTHER PROBLEMS, NEEDS, OR CONCERNS?_____
WHAT MEDICATION(S) IS YOUR CHILD CURRENTLY TAKING?_____
CAN YOUR CHILD PARTICIPATE IN A FULL PHYSICAL EDUCATION PROGRAM?_____
IF NOT, WHY?_____
AGE CRAWLED_____ AGE TALKED_____ AGE WALKED_____ BIRTH WEIGHT_____
IS YOUR CHILD POTTY TRAINED? YES_____ NO_____
DOES ANYONE IN THE FAMILY HAVE: (PLEASE CIRCLE AND EXPLAIN ON BACK OF THIS FORM)

TB HEART DISEASE CANCER EPILEPSY DEAFNESS ALLERGY DIABETES ASTHMA

KIDNEY CONDITION BLINDNESS VISION PROBLEM NERVOUS BREAKDOWN

PARENT OR GUARDIAN SIGNATURE_____ DATE_____

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