Bristol-Burlington Health District

SCHOOL HEALTH SERVICES
Health History

This form is to be completed by the child's parent/legal guardian.

SCHOOL: ______________________________ **GRADE:** ____________

STUDENT'S NAME: ______________________________ **SEX:** ______ **DOB:** __________

ADDRESS: ______________________________ **PHONE:** ______________

NAMES OF PARENTS/LEGAL GUARDIANS **WORK/CELL NUMBERS**

______________________________ ______________________________

______________________________ ______________________________

The child lives with: ______________________________**Phone number:** ______________
After school care provider: ______________________________**Phone number:** ______________

The child attended Preschool: Yes_____No_____ Name of Preschool: ______________________________
List of previous schools: ______________________________

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STUDENT'S FAMILY HISTORY: **(If living, state name and present health condition. If deceased, please list cause of death).**

Student's Father: ______________________________
Student's Mother: ______________________________
Student's Brothers: ______________________________
Student's Sisters: ______________________________.

RECORD OF ILLNESS: (Check the disease/condition that pertains to your child. Please list date and/or age).

Anemia ______	**Bleeding Disorder** ______	**Diabetes** ______
Heart Disease ______	**Asthma**______	**Pneumonia** ______
Rheumatic Fever ______	**Scarlet Fever** ______	**Tuberculosis** ______
Chronic Ear Infections ______	**Strep Throat** ______	**Other Resp. Illness** ______
Kidney Disease ______	**Meningitis**______	**Chickenpox** ______
Hernia_____ ______	**Food Allergy**______	**Environmental Allergy**______
Latex Allergy______	**Bee Sting Allergy**______	**Lead Poisoning** ______
Eczema ______	**Lyme disease** ______	**Serious Injuries**______
Surgery ______	**Frequent Nosebleeds**______	**Headaches/Migraines**______
Seizures ______	**Scabies** ______	

Other Illness/ Medical Condition: ______________________________

PLEASE INDICATE YES/NO TO THE FOLLOWING:

Wears Glasses/Contacts (Circle one) ________ **Use of Special Equipment (indicate Type):**______________
Wears Hearing Aid: R____ L____ Both____ **Ear tubes: R_____ L______ Both______**

Takes Medication daily (indicate name):______________________________

Signature: ______________________________ **Date:** ______________________
(Parent/Legal Guardian)

Revised 2//6/13 cp