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 / YEAR	_____	____	CHICKENPOX	____	______	____
6 OR MORE SORE THROATS/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 HANDICAPS?____

WHAT MEDICATIONS IS YOUR CHILD ON NOW?____
CAN YOUR CHILD PARTICIPATE IN FULL PHY. ED. PROGRAM?_______IF NOT, WHY?___________________________
AGE CRAWLED_________AGE TALKED_________ AGE WALKED_________
AGE TOILET TRAINED: BLADDER_________ BOWEL_________ BIRTH WEIGHT______________

DOES ANYONE IN THE FAMILY HAVE: (PLEASE CIRCLE AND EXPLAIN ON BACK OF THIS FORM)

TB	HEART DISEASE	CANCER	EPILEPSY	DEAFNESS	ALLERGY
DIABETES	KIDNEY CONDITION	ASTHMA	BLINDNESS	VISION PROBLEM	
NERVOUS BREAKDOWN					

DATE_____________________ PARENT OR GUARDIAN SIGNATURE____________________________________

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