

## 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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