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: _____
_____

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)