

**BROOKFIELD PUBLIC SCHOOLS
BROOKFIELD, CT 06804**

STUDENT HEALTH HISTORY

Student's Last name **First** **Middle** **Gender** **Birth date** **Grade**

Please complete all the items below by marking the yes or no box. If an item is marked yes, indicate the date(s) of the occurrence. Space is provided for any additional comments you may have relative to health issues.

A. CHILDHOOD ILLNESSES	YES	NO	DATE(S)	H. RESPIRATORY	YES	NO	DATE(S)
Lyme Disease				Asthma			
Meningitis				Inhaler required in school			
Rheumatic Fever				Wheezing or difficulty breathing with exercise			
Varicella/Chickenpox				Frequent colds/cough			
B. SEVERE ALLERGIES (Explain below)				Pneumonia/bronchitis			
Bee Sting				I. SKELETAL			
Food				Broken bones			
Drug				History of scoliosis			
Epi-pen required				J. SKIN			
Benadryl required				Eczema			
C. CARDIOVASCULAR				Hives or rashes			
History of heart disease				K. URINARY			
Surgical Procedures				History of urinary infection			
D. EARS, NOSE and THROAT				History of urinary tract condition			
Hearing impairment				L. SPECIAL CONSIDERATIONS			
More than 2 ear infections/year				Diabetes			
Ear tubes				Other chronic condition			
Frequent nosebleeds				Under the care of a specialist			
More than 2 throat infections/year and/or strep				Special Needs (OT,PT, bracing)			
E. EYES				Physical Restriction			
History of eye problems				Medication on a regular basis			
Glasses/contacts for reading/distance				Medical/Religious Exemption			
F. GASTROINTESTINAL				M. HOSPITALIZATIONS			
Frequent stomachaches/constipation/diarrhea				Include reasons under comments			
Food sensitivity or intolerance (Explain below)				COMMENTS			
G. NEUROMUSCULAR							
History of neuromuscular condition							
History of seizure disorder							

Continue on back if necessary

*In case of serious injury or illness at school, your child will be sent to an emergency medical facility.
The parent/guardian will be contacted immediately and is responsible for all expenses.*

Physician's Name: _____ Telephone: _____

Dentist's Name: _____ Telephone: _____

Parent/Guardian Signature

Date