School Health Services **HEALTH HISTORY** Brookline, Mass.
(Completed by parent/guardian)

SCHOOL_____GRADE_____ DATE _____

Name of Child _____Sex_____ Date of Birth_____ Place of Birth_____
Home Address_____Phone _____
Persons residing at home [list] _____
_____

FAMILY HISTORY-PARENTS AND SIBLINGS (Use back if extra space is needed)

	Birth Date/Place	Occupation/Address/Phone	Health Problems
Parent_____	_____	_____	_____
Parent_____	_____	_____	_____

Sibling's Name/Sex	Birth Date/Place	School & Grade	Health Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CHILD EARLY HISTORY
Problems during Pregnancy_____
Length of Pregnancy _____ Birth Weight _____ Type of Delivery_____
Problems during Delivery_____

DEVELOPMENTAL HISTORY
Sat Alone_____ Spoke in Short Sentences_____
Crawled _____ Was Toilet Trained – Day _____Night _____
Walked_____ Dressed Self _____

HEALTH STATUS
yes no
__ __ ALLERGIES: To What_____Treatment_____
__ __ ASTHMA/BREATHING DIFFICULTIES: Treatment _____
__ __ CONVULSIONS/SEIZURES/FAINTING SPELLS: Treatment_____
__ __ HEARING/EAR or VISION/EYE PROBLEMS: Treatment_____
__ __ OPERATIONS: Type & Date_____
__ __ VARICELLA /CHICKEN POX DISEASE: Date_____
__ __ OTHER MEDICAL ISSUES, including serious injuries, hospitalizations_____
_____ Treatment_____
__ __ CAN YOU CHLD PARTICIPATE IN FULL SCHOOL ACTIVITIES including PHYSICAL EDUCATION, RECESS and FIELD TRIPS? If no, explain.
__ __ DOES YOUR CHILD TAKE MEDICATIONS? List all medications with diagnosis, if not listed above.
_____
_____
_____

List any additional information on the back and return to the nurse <u>before</u> your child attends school.

MEDICAL CARE
FamilyDoctor/Pediatrician/Clinic_____
Address_____Phone_____
Special Consultant_____Type_____
Address_____Phone_____
Dentist/Clinic_____
Address _____ Phone_____

Signature of Parent _____

HEALTH REQUIREMENTS FOR NEW STUDENTS ENTERING BROOKLINE PUBLIC SCHOOLS

Student Health Services

Dear Parents/Guardians:

Welcome to the Brookline Public Schools. Health Services invites you to partner with your school nurse, to promote an optimal educational opportunity for your child that is supported by a coordinated and comprehensive school health program.

Massachusetts Department of Public Health requires that a student may enter school only after the following requirements are met:

- **Health History** completed by parent/guardian prior to enrollment.
- **Physical Examination** performed and signed by a US health care provider completed within one year *prior* to entry.
- **Lead level** and **vision screening** completed before entry to kindergarten. Your health care provider is required to test your child's vision. Please have your PCP include the results with the immunization record or physical exam.
- **Immunization** documentation must be translated and is required before entry. Dates must include month and year and in some cases, exact day may be necessary to fully establish your child's immune status. (Schedule below).

Please arrange to meet with your school nurse to plan for any special health care needs or for the administration of any essential medications or procedures that are prescribed during the school day.

Massachusetts Department of Public Health
School Immunization Regulations

REQUIRED for SCHOOL ENTRY 2015-16

	Preschool/PK	K –Grade 3	Grades 4-6 and 11-12	Grades 7-10
Hepatitis B	3 doses	3 doses	3 doses	3 doses
DTaP/DPT/DT/Td[1]	≥4 doses	≥4 doses	≥4 doses	≥4 doses plus 1 Tdap booster
Polio[2]	≥3 doses	≥3 doses	≥3 doses	≥3 doses
Hib	1-4 doses	--	--	--
MMR[3]	1 dose measles 1 dose mumps 1 dose rubella	2 doses measles 2 doses mumps 2 doses rubella	2 doses measles* 1 dose mumps* 1 dose rubella*	2 doses measles 2 doses mumps 2 doses rubella
Varicella[3]	1 dose	2 doses	1 dose *	2 doses

[1]Five doses unless 4th dose was given after 4th birthday, then only 4 doses.

[2]Four doses unless 3rd dose was given after 4th birthday, then only 3 doses.

3 Measles and Varicella vaccinations must have been given on or after 1st birthday.

* **Two doses of MMR and two doses Varicella or MMRV combined is highly recommended.**
(Physician verification of disease or serologic proof of immunity is acceptable.)

Tricia Laham, RN, MEd, NCSN
Coordinator of Student Health Services

L. Erik von Hahn MD
Physician Consultant