Bristol Township School District

STUDENT HEALTH HISTORY FORM

The Bristol Township School District requests that the parents/guardians of all incoming students complete the following confidential Health History to help the school nurse develop a Care Plan for your child, should your child need medical, physical, emotional, social and/or academic assistance. If you have any questions, please feel free to contact the school nurse.

Student's Name____Birth Date____________Grade______Sex______

Home Address_____________________________________City_____________Zip________Home Phone_____________

Student Lives with: ____

Parent/Guardian's Name ___________________________Work#_____________________Cell#____________________

Parent/Guardian's Name ___________________________Work#_____________________Cell#____________________

List all people living in household:

	Name	Sex	Relationship to Student	Occupation or Grade/Age (if sibling)
1.				
2.				
3.				
4.				

Name of last school attended____Phone #________________________

Address____City________________State_______Zip________

The Pennsylvania Department of School Health requires a physical examination in grades K, 6 and 11. They also require a dental examination in grades K, 3 and 7. These examinations are also required for those students with incomplete health records. The examinations will be accepted if completed one year before the school year begins.

Please indicate below your preference for the completion of the mandated physical and/or dental examinations. If you choose to have your student seen by the school district's dentist or physician, it will be FREE and of no cost to you. If you do not provide your child's exam by October 1st of the school year the exam is needed, your child will be scheduled to see our school physician.

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I prefer our ***PRIVATE PHYSICIAN/DENTIST*** to do the physical/dental examination.

DATE OF EXAMINATION(S): Physical______________________ Dental_________________________

I prefer the ***SCHOOL PHYSICIAN*** do the physical examination.

I prefer the ***SCHOOL DENTIST*** to do the dental examination.

If you do not have Health Insurance, Dental Insurance and/or Vision Insurance, contact your school nurse for more information regarding free/low cost dental, vision and health care.

Please check if your student <u>FREQUENTLY</u> experiences any of the following:

Nosebleeds	Diarrhea	Poor sleep patterns	Poor eating patterns
Colds	Stomachaches	Nightmares	Difficulty breathing through nose
Sore throats	Headaches	Stammering/Stuttering	Breathless with activity
Urination	Dental problems	Persistent coughing	Pains in arms/legs
Constipation	Chest pain	Earaches/drainage	Stumbles or drops things

Medical History – Please check all that apply.

ADD/ADHD	Abnormal Blood Lead Levels	Endocrine Disorder	Orthopedic Condition
Anemia	Chemical/Hormonal Imbalance	Fainting Spells	Neurological Disorder
Arthritis	Color Vision Deficit/Blindness	Hay Fever	Psychiatric Condition
Asthma	Connective Tissue Disorder	Heart Disorder	Scoliosis
Bleeding Problem	Developmental Delay	Heart Murmur	Seizure Disorder
Blood Disorder	Drug/Tobacco/Alcohol Usage	Head/Neck Injury	Short Stature
Cancer	Emotional/Behavioral Condition	Hernia	Sickle Cell Anemia
Cerebral Palsy	Joint/Bone/Muscle Problem	High Blood Pressure	Skin Disorder
Cystic Fibrosis	Immunosuppressive Disorder	Kidney Problem	Speech Problems
Dental Condition	Muscular Dystrophy	Liver Problem	Spina Bifida
Diabetes	Neuromuscular Disorder	Lung Condition	Tuberculosis
Dietary Restrictions	Stomach/Intestinal Disorder	Migraine Headaches	Underweight
Eating Disorder	Tourette's Syndrome	Overweight	Other____________________

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Explain condition(s) checked above or any other medical condition(s):____

____

Allergies: Food Insect/Bee Medication Plants Animals Seasonal Environmental Other________________
Specify allergy(ies), reaction(s) and treatment(s)____

Hearing/Ear Problems: Yes No. If yes, type_________________ Tubes? Yes No Hearing aide(s)? Yes No

Vision Problems: Yes No. If yes, diagnosis______________________________ Wears glasses/contacts? Yes No

Recurring illness/infection: Yes No. If yes, explain____

List major injuries, operations and/or hospitalizations:____
____

Does any of the above prevent full participation in any school or physical education program? Yes No
If yes, explain:____

List medication(s) taken at home regularly____

List any medication to be taken at school*____
***physician's orders are required**

May the school staff be informed of your student's health history? Yes No

Would you like a conference with the school nurse? Yes No

Parent/Guardian Signature____ **Date**_______________