SCHOOL DISTRICT OF BRISTOL TOWNSHIP
HEALTH HISTORY

School _____ Grade _____ Date _____

Child's Name _____ **Sex** _____ **D.O.B.** _____

School and District last attended: _____

Current Address _____ Home Phone _____

Mother's Name _____ Phone number _____

Father's Name _____ Phone Number _____

Guardian's Name _____ Phone number _____

Parents Email Addresses _____

Child's Physician _____ Phone number _____

Does your child have an IEP or 504 Plan? _____

DOES YOUR CHILD HAVE:	YES	NO	**HAS YOUR CHILD EVER HAD:**	YES	NO
ASTHMA/WHEEZING	_____	_____	CONCUSSION	_____	_____
SEASONAL ALLERGIES	_____	_____	SEIZURES	_____	_____
FREQUENT EAR INFECTIONS	_____	_____	FAINTING SPELLS	_____	_____
HEARING PROBLEMS	_____	_____	MONO	_____	_____
WEAR HEARING AIDS	_____	_____	HEPATITIS	_____	_____
VISION PROBLEMS	_____	_____	CHICKEN POX	_____	_____
GLASSES PRESCRIBED	_____	_____	MEASLES	_____	_____
SPEECH DIFFICULTIES	_____	_____	GERMAN MEASLES	_____	_____
EMOTIONAL ISSUES	_____	_____	MUMPS	_____	_____
EXTREME ACTIVITY	_____	_____	WHOOPING COUGH	_____	_____
FREQUENT FALLS	_____	_____	POLIO	_____	_____
FREQUENT STOMACHES	_____	_____	RHEUMATIC FEVER	_____	_____
FREQUENT HEADACHES	_____	_____	OTHER _____		
CARDIAC ISSUES	_____	_____	_____		
HEART MURMUR	_____	_____	_____		

LIST ALLERGIES AND REACTION: _____

SURGERIES (type and date): _____

MEDICATIONS: _____

OTHER PROBLEMS, NEEDS OR HANDICAPS: _____

_____

CAN YOUR CHILD FULLY PARTICIPATE IN PHYSICAL EDUCATION CLASS? _____, IF NOT PLEASE EXPLAIN:

_____

PLEASE COMPLETE OTHER SIDE----->

DEVELOPMENTAL MILESTONES

AGE CRAWLED _____ AGE TALKED _____ AGE WALKED _____

AGE TOILET TRAINED: Bladder _____ Bowel _____ BIRTH WEIGHT _____

FAMILY HEALTH HISTORY (please circle and explain below)

TB	SEIZURES	CANCER	MENTAL HEALTH DISORDER
DIABETES	VISION PROBLEMS	DEAFNESS	ALLERGIES
ASTHMA	HEART ISSUES	KIDNEY PROBLEMS	

_____

_____

_____

PARENT SIGNATURE _____ **DATE** _____