Bradford Area School District

Student Health History

Student Name:_____ Date of Birth:_____

Today's Date:_____

Developmental History:

Was child born Premature/Early?:_____ Problems in Hospital after birth_____

Approximate age that Child:

Walked:_____ Talked:_____ Potty Trained:_____

Did your child require any services through Early Intervention (speech, Physical therapy, occupational therapy)? (List)_____

_____

Medical History: **Please fill out completely**

Allergies (Medications, foods, plants, environmental, bees etc.) _____

_____

_____

Any Medications your child takes (prescription and over the counter)_____

_____

Any Health Problems or Chronic Illness:_____

_____

Surgeries or Hospitalizations (with approximate age or year)_____

_____

Any History of the following: (Please provide Year or age of student)

Asthma_____ Diabetes_____ Fainting Spells_____

Pneumonia_____ Frequent Ear infections_____ Heart Problems:_____

Seizures (Describe): Febrile(fever)_____OR__Seizure Disorder_____

Whooping cough_____ Rheumatic Fever_____ Chicken Pox_____

Urinary problems_____ Stomach/Intestinal problems_____ Tuberculosis_____

Other (explain):_____

_____

Nutrition: Special Diet Required:_____ Picky Eater:_____

Emotional History (yes or no):

Abnormal Sleep Patterns_____ Bed Wetting:_____ Disobedient_____

Temper Tantrums_____ Fights with other children_____

History of any traumatic event for student: (death of a parent, foster care, divorce)

_____

Child's Primary Doctor:_____ phone number_____

Any specialists that your child sees (allergist, ENT, cardiologist, neurologist, etc):

Doctor:_____ phone number_____

Doctor:_____ phone number_____

Doctor:_____ phone number_____

Child's Dentist:_____ Phone number_____

_____ _____

Signature of person completing form Relationship to student