

**Bedford Public Schools**  
**Student Health History**

Dear Parents:

We would like your child to gain the most from his/her school experience. Please fill out this brief health history form on your child. This information will help the nurse to better understand your child and assist in the transition into school life. Please complete this form and return it with a copy of your child's most recent physical exam and immunizations (please see health requirements checklist).

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_

1. Does your child have any of the following conditions?

___ Asthma	___ Allergies	___ Hearing Problems
___ Diabetes	___ ADD/ADHD	___ Ear tubes
___ Seizure Disorder	___ Bleeding Disorder	___ Stomach/Bowel Problems
___ Heart Condition	___ Vision Problems	

If you have checked yes to any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Does your child have any other medical conditions? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Will your child need any medication during the school day? If so, please list: \_\_\_\_\_

\_\_\_\_\_

4. Does your child take medication routinely at home? If so, please list: \_\_\_\_\_

\_\_\_\_\_

5. Has your child ever been hospitalized? If so, please explain: \_\_\_\_\_

\_\_\_\_\_

6. Has your child ever had surgery? \_\_\_\_\_ Date of surgery: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

\_\_\_\_\_

7. Do you have concerns about your child's vision or hearing? \_\_\_\_\_

\_\_\_\_\_

8. Do you have other children that have been diagnosed with a chronic illness? \_\_\_\_\_

\_\_\_\_\_

9. Do you have any concerns about your child's mental, social/emotional health or adjustment concerns?

\_\_\_\_\_

\_\_\_\_\_

10. Please list other children in household (name/age): \_\_\_\_\_

\_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

If your child has a health condition that will require further conversation, please call the school nurse to schedule a meeting.