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.