Central Bucks School District
School Health Services Health History
(to be completed upon enrollment)
A copy of the student's current immunizations is required to register.
To Parents or Guardian: The following information is requested for our records.

Grade Entering _______________ Date ____________________

Previous school attended _____________________________________ State ______________________________

Address ____ City ___________________________

Student's Name ____Home Phone ________________________
Last First Middle

Birthdate _______________________ Male_____ Female_____ Parent's Work Phone _________________
Month/Day/Year

Mailing Address:____
Street City/Town Zip

Father ____Mother ____
Last First Last First

Guardian____ Relationship ___________________________
Last First

Student's Physician ___________________ Date of last exam _________ Health Insurance_____________

Student's Dentist _____________________Date of last exam _________ Dental Insurance______________

Are Community Services needed? Free Dental and Health Care?___________ Yes _______No
Free/Reduced Lunch Program? _________ Yes _______No

A. Disease History/ Illnesses
Check any of the following and put a date next to all that apply.

Chicken Pox _______ Lyme Disease ______ Kidney Disease________Bleeding Disorder______
Pneumonia _________Heart Disease _____ Gastrointestinal ________Seizure Disorder_______
Diabetes____________ ADD ADHD ________ Headaches____________Skin Disorder __________
Please describe: ____

B. Health History Please check yes or no.

1. Does your child have frequent ear infections or trouble hearing? No Yes
2. Does your child have any trouble with eyes or vision ? No Yes
3. Has your child ever had a serious illness? No Yes
4. Has your child ever had any surgery? No Yes

Please describe if the answer was "yes" to any of the above questions

C. Allergy History
1. Does your child have any environmental allergies? No Yes
Explain ____
2. Has your child ever had an allergic reaction to **any** medications? No Yes
Please describe what happened. ____
3. Has your child had an allergic reaction to any foods? No Yes

Please describe what happened.

4. Has your child ever had an adverse reaction to an insect sting? No Yes
Please describe what happened. ____

5. Does your child have asthma ? No Yes

A. What type of asthma (allergic, exercise induced, etc.)?

B. Your child's best Peak Flow reading

C. Please list any medication(s) your child takes for asthma and the frequency it is taken.

D. **Medication History**

Does your child take medication on a daily basis? No Yes

Please list any medications taken and describe what the medication is for.

Has your child ever had a serious illness ? No Yes
What and when ?

E. Social History

Have there been any changes in your family during the past year, such as:

1. Separation, divorce, or remarriage? No Yes
2. Death or serious illness? No Yes
3. Any other situation which may affect your son/daughter? No Yes

If yes, please explain

F: Miscellaneous

Please list any condition your child may have which might limit his/her activities in school. Please include any other comments you think might be helpful.

Thank you for completing this form