BROOKFIELD PUBLIC SCHOOLS
BROOKFIELD, CT 06804

STUDENT HEALTH HISTORY

Student's Last name	First	Middle	Gender	Birth date	Grade

Please complete all the items below by marking the yes or no box. If an item is marked yes, indicate the date(s) of the occurrence. Space is provided for any additional comments you may have relative to health issues.

A. CHILDHOOD ILLNESSES	YES	NO	DATE(S)	H. RESPIRATORY	YES	NO	DATE(S)
Lyme Disease				Asthma			
Meningitis				Inhaler required in school			
Rheumatic Fever				Wheezing or difficulty breathing with exercise			
Varicella/Chickenpox							
B. SEVERE ALLERGIES (Explain below)				Frequent colds/cough			
Bee Sting				Pneumonia/bronchitis			
Food				I. SKELETAL			
Drug				Broken bones			
Epi-pen required				History of scoliosis			
Benadryl required				J. SKIN			
C. CARDIOVASCULAR				Eczema			
History of heart disease				Hives or rashes			
Surgical Procedures				K. URINARY			
D. EARS, NOSE and THROAT				History of urinary infection			
Hearing impairment				History of urinary tract condition			
More than 2 ear infections/year				L. SPECIAL CONSIDERATIONS			
Ear tubes				Diabetes			
Frequent nosebleeds				Other chronic condition			
More than 2 throat infections/year and/or strep				Under the care of a specialist			
E. EYES				Special Needs (OT,PT, bracing)			
History of eye problems				Physical Restriction			
Glasses/contacts for reading/distance				Medication on a regular basis			
F. GASTROINTESTINAL				Medical/Religious Exemption			
Frequent stomachaches/constipation/diarrhea				M. HOSPITALIZATIONS			
Food sensitivity or intolerance (Explain below)				Include reasons under comments			
G. NEUROMUSCULAR				COMMENTS			
History of neuromuscular condition							
History of seizure disorder							

Continue on back if necessary

In case of serious injury or illness at school, your child will be sent to an emergency medical facility. The parent/guardian will be contacted immediately and is responsible for all expenses.

Physician's Name: ______________________________ Telephone: ______________

Dentist's Name: ______________________________ Telephone: ______________

______________________________ ______________
Parent/Guardian Signature Date