BETHEL PARK SCHOOL DISTRICT

STUDENT HEALTH HISTORY FORM

The Bethel Park School District requests that the parents/guardians of all incoming students complete the following confidential Health History **(2 pages)** to help the school nurse develop a Care Plan for your child, should your child need medical, physical, emotional, social and/or academic assistance. If you have any questions, please feel free to contact the school nurse.

Student's Name_____Birth Date_____Grade_____Sex_____
Home Address_____City_____Zip_____Home Phone_____

Student Lives with: _____

Parent/Guardian's Name _____Work#_____Cell#_____

Parent/Guardian's Name _____Work#_____Cell#_____

List all people living in household:

	Name	Sex	Relationship to Student	Occupation or Grade/Age (if sibling)
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Name of last school attended_____Phone #_____
Address_____City_____State_____Zip_____

The Pennsylvania Department of School Health requires a physical examination in grades K, 6 and 11. They also require a dental examination in grades 3 and 7. These examinations are also required for those students with incomplete health records. The examinations will be accepted if completed one year <u>before</u> the required grade.

Please indicate below your preference for the completion of the mandated physical and/or dental examinations. If you choose to have your student seen by the school district's dentist or physician, it will be <u>FREE</u> and of no cost to you.

◯ I prefer our ***PRIVATE PHYSICIAN/DENTIST*** to do the physical/dental examination.
DATE OF EXAMINATION(S): Physical_____ Dental_____

◯ I prefer the ***SCHOOL PHYSICIAN*** do the physical examination.

◯ I prefer the ***SCHOOL DENTIST*** to do the dental examination.

If you do not have Health Insurance, Dental Insurance and/or Vision Insurance, the school nurse can share information with you regarding free/low cost dental, vision and health care.

Would you like for the nurse to send you this information? ☐ Yes ☐ No

Please check if your student FREQUENTLY experiences any of the following:

□ Nosebleeds	□ Diarrhea	□ Poor sleep patterns	□ Poor eating patterns
□ Colds	□ Stomachaches	□ Nightmares	□ Difficulty breathing through nose
□ Sore throats	□ Headaches	□ Stammering/Stuttering	□ Breathless with activity
□ Urination	□ Dental problems	□ Persistent coughing	□ Pains in arms/legs
□ Constipation	□ Chest pain	□ Earaches/drainage	□ Stumbles or drops things

Medical History – Please check all that apply.

□ ADD/ADHD	□ Abnormal Blood Lead Levels	□ Endocrine Disorder	□ Orthopedic Condition
□ Anemia	□ Chemical/Hormonal Imbalance	□ Fainting Spells	□ Neurological Disorder
□ Arthritis	□ Color Vision Deficit/Blindness	□ Hay Fever	□ Psychiatric Condition
□ Birth Defect	□ Connective Tissue Disorder	□ Heart Disorder	□ Scoliosis
□ Bleeding Problem	□ Developmental Delay	□ Heart Murmur	□ Seizure Disorder
□ Blood Disorder	□ Drug/Tobacco/Alcohol Usage	□ Head/Neck Injury	□ Short Stature
□ Cancer	□ Emotional/Behavioral Condition	□ Hernia	□ Sickle Cell Anemia
□ Cerebral Palsy	□ Joint/Bone/Muscle Problem	□ High Blood Pressure	□ Skin Disorder
□ Cystic Fibrosis	□ Immunosuppressive Disorder	□ Kidney Problem	□ Speech Problems
□ Dental Condition	□ Muscular Dystrophy	□ Liver Problem	□ Spina Bifida
□ Diabetes	□ Neuromuscular Disorder	□ Lung Condition/Asthma	□ Tuberculosis
□ Dietary Restrictions	□ Stomach/Intestinal Disorder	□ Migraine Headaches	□ Underweight
□ Eating Disorder	□ Tourette's Syndrome	□ Overweight	□ Other_____

Explain condition(s) checked above or any other medical condition(s):_____

_____

Allergies: □ Food □ Insect/Bee □ Medication □ Plants □ Animals □ Seasonal □ Environmental □ Other_____

Specify allergy(ies), reaction(s) and treatment(s)_____

Hearing/Ear Problems: □ Yes □ No. If yes, type_____ Tubes? □ Yes □ No Hearing aide(s)? □ Yes □ No

Vision Problems: □ Yes □ No. If yes, diagnosis_____ Wears glasses/contacts? □ Yes □ No

Recurring illness/infection: □ Yes □ No. If yes, explain_____

List major injuries, operations and/or hospitalizations:_____

_____

Does any of the above prevent full participation in any school or physical education program? □ Yes □ No

If yes, explain:_____

List medication(s) taken at home regularly_____

List any medication to be taken at school_____

May the school staff be informed of your student's health history? □ Yes □ No

Would you like a conference with the school nurse? □ Yes □ No

Parent/Guardian Signature_____ **Date**_____