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**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: □Both Parents □Mother □ Step-mother □ Father □ Step-father □Guardian □ Other

Father’s Name \_Work # Cell #

Mother’s Name Work # Cell #

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 before 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 FREE 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

1

**□**

**□**

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

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

**Medical History – Please check all that apply.**

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

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