HILLSBOROUGH TOWNSHIP PUBLIC SCHOOLS

Student Health Information

To be completed by parent or guardian & placed in student's health folder

Enclosure D

Student's Name: Last: ______________ First: ______________ Middle: ______________ D.O.B.: ___________ Male ☐ Female ☐

All students must have official Proof of Immunizations prior to entering school.

Family Physician ______________ Address: ______________ Telephone#: (____) ______________

Birth History: Full term birth: ____ Premature birth_____ Type of delivery: cesarean / vaginal Birth weight: ________ Condition/complications at birth: ______________

Developmental history: Age of standing: _____ walking: ________ talking: ________ bowel control: _______ bladder control: ________ other:

____

Past Medical History: (please check all that apply and give approximate year)

( ) Allergic to: ______________
( ) Asthma: _______
( ) Cerebral Palsy
( ) Chicken Pox date: _____/ vaccine date: _______
( ) Diabetes: _______
( ) Drug allergy: ______________
( ) Eczema: ________
( ) Epilepsy: ________
( ) Hayfever: ________
( ) Heart Disease: ________
( ) Hepatitis: ________
( ) Kidney Disease : ________
( ) Lyme Disease: _______
( ) Mononucleosis: _______
( ) Pneumonia: _________
( ) Poliomyelitis: ________
( ) Rheumatic fever: _________
( ) Scarlet fever: _________
( ) Strep infections : ______________
( ) Dietary restrictions: ______________
( ) Other: ______________

Tuberculosis: Have you had any contact with anyone who has or might have Tuberculosis? Yes ☐ No☐; Tuberculin test: Date: ______________ Type: ______________ Results: ______________

Surgical history: (please supply dates of any operations/hospitalizations)

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Significant injuries or medical concerns:

____

____

Is student on any daily medication? Yes ☐ No ☐; if yes, specify name and dosage: ______________

Is there any past or present physical condition or any special disability that the school should know about? Yes ☐ No ☐; please specify: ______________

____

☒ I would like to discuss my child's health history with the school nurse. Yes ☐ No ☐

☒ Medical information will be shared with the appropriate school staff.

Parent/Guardian Signature ______________ Date ______________

Parent/Guardian Printed Name ______________

HBE: 1230 Health History Rev. 6/05