

**OFFICE OF HEALTH SERVICES
BRIDGEPORT PUBLIC SCHOOLS
BRIDGEPORT, NEBRASKA**

NAME: _____ BIRTHDATE: _____

PARENTS: _____

ADDRESS: _____ PHONE: _____

OTHER EMERGENCY PHONE: _____

PHYSICIAN: _____ PHONE: _____

DENTIST: _____ PHONE: _____

OPTOMETRIST: _____ PHONE: _____

A. MEDICAL HISTORY (check the ones that apply to your child)

- | | |
|---|--|
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Frequent sore throats |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeder |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures** |
| <input type="checkbox"/> Bone disease | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Frequent earaches | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Mouth breather |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Speech difficulty |
| <input type="checkbox"/> Convulsions w/fever | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Tubes in ears |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Tires easily |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Frequent stomachaches |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Color blindness | |

**Are seizures: Petit mal Grand mal
 Psychomotor Partial

B. ALLERGIES

- | | | |
|------------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Dust | <input type="checkbox"/> Mold | <input type="checkbox"/> Bees |
| <input type="checkbox"/> Cut Grass | <input type="checkbox"/> Pollens | <input type="checkbox"/> Animals |
| <input type="checkbox"/> Foods | <input type="checkbox"/> Drugs | <input type="checkbox"/> Other _____ |

Please describe the allergic reaction: _____

C. MEDICATIONS

1. Is medication needed for allergy:

At home? Yes _____ No _____
At school? Yes _____ No _____

Name of medication: _____

2. Is medication needed for any other condition? If yes, what condition?

At home? Yes _____ No _____
At school? Yes _____ No _____

**IF MEDICATION IS NEEDED AT SCHOOL, PLEASE REQUEST
OFFICIAL MEDICATION FORM FROM THE SECRETARY.**

D. Is there a health problem and/or handicap present? Yes _____ No _____

What is the diagnosis? _____

At what age was the diagnosis made? _____

List physician that made the diagnosis: _____

E. List any operations, injuries, or hospitalizations and dates: _____

Do any of the above conditions still affect your child? _____

If yes, please list: _____

F. Does your child's condition restrict his/her participation in any physical education activity? _____

G. Does your child wear glasses? Yes _____ No _____
Contact lenses? Yes _____ No _____

H. Last eye exam (date): _____ by Dr. _____

Last dental exam (date): _____ by Dr. _____

Last medical exam (date): _____ by Dr. _____

The following information will help the school staff understand your child better: Describe your child today. What is he/she like? _____

Do you have any concerns about your child or do you wish help in working with any problems you feel your child has? _____

Thank you very much for taking the time to fill out this medical history form. In the even your child's medical history changes, please notify the School Nurse at 262-1574 or 262-0346.

DATE: _____ **PARENT SIGNATURE:** _____