BURRELL SCHOOL DISTRICT
HEALTH HISTORY

School: _____ **Date:** _____

To Parent or Guardian:

The information requested below will be of help to the school authorities in determining the health status of your child and in assisting him/her to receive the maximum benefits from his/her educational opportunity.

Name of Child (last, first, middle)	Birthdate: ☐ Male ☐ Female
Address	Phone Number
Father's Name (last, first, middle)	Mother's Name (last, first, middle)

Person with whom pupil lives (if other than both parents):

_____

MEDICAL HISTORY

Give year if child has had any of following conditions:

Allergy	ADD/ADHD	Bleeding Disorder
Asthma	Heart Condition	Neurological Condition
Bronchitis	Kidney Condition	Muscular/Skeletal
Chicken Pox	PDD/Autism	Tuberculosis
Seizures	Premature Birth	Whooping Cough
Diabetes	Digestive Condition	OTHER
Psychiatric	Learning Disability	OTHER

Operations:

_____
(type) (year)

Serious Injuries:

_____
(type) (year)

Emotional Problems: _____
Under Doctor's Care For: _____
Medication(s): _____
Family Dentist's Name: _____
Family Physician's Name: _____

Parent's Signature: _____ **Date:** _____