Bourne Public Schools

Student Health History

Students Name: _____ Date of Birth: _____

Place of Birth: _____

Address: _____ Phone: _____

Mailing Address: (if different from above) _____

Parent / Guardian: _____ Occupation: _____

Parent / Guardian: _____ Occupation: _____

Where did your child last attend school? _____

Names and birth dates of other children in your family:

Name	Birth Date

Immunizations: Massachusetts Law requires that all children enrolling in Public School must be immunized. Your child's immunization record will be photocopied and returned to you.

Child's Pediatrician/Physician: _____ Phone: _____

Date of Last Physical: _____

Child's Dentist: _____ Phone: _____

Other Specialists: _____ Phone: _____

Is your child capable of participating in a full program of school activities including recess and physical education?

☐ Yes ☐ No

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Student Name: _____

CURRENT HEALTH CONCERNS	YES	NO	IF YES, PLEASE EXPLAIN
Does your child have allergies			☐ Food ☐ Insects ☐ Medications ☐Other
Does your child have vision problems or wear glasses?			
Does your child have any hearing problems?			
Is your child taking any prescribed medications on a daily basis?			
Will your child be taking any medication at school?			
Does your child have asthma?			
Does your child have diabetes?			
Does your child have a chronic illness or condition?			
Does your child have headaches?			
Does your child have bowel or bladder problems?			
Is there anything else we should know about your child's health?			
PAST HEALTH CONCERNS			
Does your child have any history of heart problems?			
Has your child ever had surgery?			
Has your child ever had seizures?			
Has your child ever had chicken pox?			
Does your child have any other health concerns?			

Do you have any questions or concerns regarding emotional or physical health issues which you would like to discuss with a nurse or school psychologist? ☐ Yes ☐ No

Parent / Guardian Signature: _____ Date: _____