**COUNCIL ROCK SCHOOL DISTRICT**
Bucks County, Pennsylvania

## Health History

Former School _____ Council Rock School _____
&
Address _____ Date of Entry _____ Grade _____

Name of Child _____ M___ F___ Birthdate _____
(Last) (First) (Middle)

Address _____ Telephone _____

Father's Name _____
(Last) (First) (Middle)

Mother's Name _____
(Last) (First) (Middle)

Person with whom pupil lives _____
(Name) (Relationship)

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## Medical History

| *Has your child had:* | Yes | No | Date / Age | If Yes / Explain |
|---|---|---|---|---|
| Chickenpox Disease? If *yes*, please add approximate date or age. | ___ | ___ | _____ | _____ |
| Any operations? | ___ | ___ | _____ | _____ |
| Any illnesses requiring hospitalizations? | ___ | ___ | _____ | _____ |
| Any broken bones? | ___ | ___ | _____ | _____ |
| Any head injuries or concussions? | ___ | ___ | _____ | _____ |
| Any dizzy spells, blackouts or loss of consciousness? | ___ | ___ | _____ | _____ |
| Any episodes of wheezing or shortness of breath? | ___ | ___ | _____ | _____ |
| Any allergies? | ___ | ___ | _____ | _____ |
| Any seizures or convulsions? | ___ | ___ | _____ | _____ |
| Any restrictions for play or physical education? | ___ | ___ | _____ | _____ |
| Is your child under treatment? | ___ | ___ | _____ | _____ |
| Is your child receiving any daily medication? | ___ | ___ | _____ | _____ |

State any other information that will aid the school to better understand your child _____

_____

_____
*Signature of Parent/Guardian* *Date*