BOW SCHOOL DISTRICT STUDENT HEALTH HISTORY BOW, NEW HAMPSHIRE

PART I – NOTE TO PARENTS

The health of children greatly influences their ability to learn. Please complete each item below and take this form to your physician at the time of your child's examination. A medical examination is required upon or prior to entrance in the public school system and thereafter as often as deemed necessary by local school authority. (RSA 200:32)

Child's Name ______________________________________ Sex: Male Female Date and Place of Birth ____

Address ____ Home Telephone # ____

Father's Name ____________________________ Daytime Telephone # _________ Mother's Name ____________________________ Daytime Telephone #__________

Family Doctor ____ Family Dentist ____

Date of last complete physical examination ____________________________ Date of last dental examination ____

	YEAR		YEAR		YEAR		YEAR
Chicken Pox		Meningitis		Ear Infection		Heart Disease	
Scarlet Fever		Bronchitis		Convulsions		Diabetes	
Strep Throat		Pneumonia		Rheumatic Fever		Cold Sores	

Asthma or allergies (type and date____

Reactions to medicines or insect stings (Explain____

Hospitalizations (reason and date) ____

Operations (type and date)____

Other illnesses or conditions not listed above (Epilepsy, etc.)

____

Treatment ____

Please comment here on any special problem(s) related to your child's heath ____

Suggestions to school____

I give my permission for the physician to complete Part II for confidential use in meeting my child's health and education needs at school.

____ ______________________

Signature of Parent or Guardian Date form completed

BOW SCHOOL DISTRICT PHYSICIAN'S MEDICAL EXAMINATION REPORT BOW, NEW HAMPSHIRE

PART II – NOTE TO PHYSICIAN

Please review the health history reported by the parents on the reverse side. Please record date of all immunizations as required by New Hampshire state law for admission to school, as well as any health deviations and tests administered. Recommendations which you feel should be carried out by the school personnel should be clearly stated on this form. Thank you for your assistance.

CHILD'S NAME: ________________________________(M)_____(F)_____

Date of Birth ____________ Date of Examination ______________________________

MEDICAL EXAMINATIONS (is normal-otherwise specify)

Height ________________________ BP _____________ Pulse ____________
Eyes __________________________ Weight ___________________________
Ears ___________________________ Nutrition _________________________
Teeth: Temporary ____________ Permanent ______________
Gums ____
Tonsils ____
Nose ____
Glands (specify) ____
Heart ____
Lungs ____
Skeletal ____
Skin or Allergy ____
Hernia ____
Genitalia ____
Nervous System (specify if Epilepsy) ___________________________________
____
Speech ____
General Condition ____

DATES VACCINE ADMINISTERED

IMMUNIZATIONS	1	2	3	4	5
Td					
TDAP					
DTP					
Polio (Oral Triv.)					
Measles					
Rubella					
Mumps					
Hepatitis B					
Varivax					
HIB					

OTHER TESTS ADMINISTERED IF NECESSARY:
Tuberculosis (Intradermal) ____
Other ____

PHYSICIAN'S RECOMMENDATIONS

Is the pupil physically capable of carrying a full program of school work including gymnastics and athletics? ___ Yes ___ No
Remarks ____
Must the school program be modified to meet the needs of this child?___ Yes__ No
By special seating ________ Dietary _________
Other ____
Does pupil have a know absence of a paired organ? ___ Yes ___ No
Eye __ Lung __ Kidney __ Testicle ___
Other ____
Does pupil require medication on a regular basis? ___ Yes ___ No
Specify ____
Is there evidence of emotional upset? ___ Yes ___ No
Recommendations ____
Would you like to discuss any of the information on this report with:
___ School Nurse ___School Physician ___Principal ___Teacher or Counselor

____

Physician (Please Print) ____

Office Address ____

Telephone Number ____

Signature of Physician ____