Braintree Public Schools Medical History

(To be completed by Parent/Guardian)

Name ____ Grade ________ School ______________________
First Middle Last

Address ____ Telephone __________________

Transfer from ____ Today's Date ________________

Date of Birth _________________________________ City/State of Birth ___________________________

Parent/Guardian Name _________________________ Relationship ______________________________

Email ____

Parent/Guardian Name _________________________ Relationship ______________________________

Email ____

Number of other children in family _________ Primary language spoken in home ________________

Name _________________ Birth Date __________ Name _________________ Birth Date __________

Name _________________ Birth Date __________ Name _________________ Birth Date __________

Child lives with: ☐ Parent/Guardian ______________ ☐ Other ____________________________________

Were there any complications at birth? ☐ Yes ☐ No If yes, please describe:_________________________

____

Has this child had any of the following: If yes, please explain:

☐ Asthma __________________________________
☐ Allergies (list) ____________________________
Epi-Pen Used ☐ Yes ☐ No
☐ Heart Problems ____________________________
☐ Kidney Problems ___________________________
☐ Diabetes _________________________________
☐ Seizures _________________________________
☐ Fractures/location/date ______________________
☐ Hepatitis ________________________________
☐ Scoliosis ________________________________
☐ Hearing Problems ________ ☐ Hearing Aides
☐ Vision Problems _________ ☐ Glasses ☐ Contacts
☐ Other:____

Does this child take any medication? If yes, please state medication and reason ___________________________

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Can this student participate in a full Physical Education Program? ☐ Yes ☐ No

If no, explain why ____

Family Physician _____________________________ Family Dentist ____________________________

I give permission to the school nurse to share the above medical information with school personnel as determined appropriate for my child's health and safety. ☐ Yes ☐ No

Parent/Guardian Signature ____

Please return completed form to the School Nurse

Updated April 27, 2018