Bethlehem Area School District
HEALTH HISTORY

Name ________________________________ Date of Birth ______________________

M / F School ______________________ Grade/Homeroom ______________________

Mother's Name______________________ Address______________________________

Father's Name______________________ Address______________________________

Custody Arrangements____

Last School Attended ______________________ County ______________________

Siblings:

Name	Age

Language Spoken at Home______________________

Name of Doctor/Clinic______________________ Dentist______________________

Immunization Record -Please attach

Hospitalizations and Surgeries

Date	Diagnosis	Procedure	Resolution

Serious Injuries

Date	Type	Resolution

Chronic or Serious Medical Conditions

Date	Type	Resolution

Medications Taken Regularly

Name of Medication	Dose	Time	Reason

Allergies

Medications____

Insects____

Foods____

Other____

Emotional Problems

Description____

Resolution____

______________________________ ______________

Parent/Guardian Signature Date

Rev. 10/2012