Baltimore County Public Schools
Towson, Maryland

Baltimore County Department of Health
Baltimore, Maryland

New Student Health History

Last Name: _____ First Name: _____ Grade: _____ Gender: Male / Female

Last school your child attended? _____ DOB: _____

Has your child traveled or resided outside of the U.S. in the past year? ☐ Yes ☐ No

If yes, list countries: _____

Where do you usually take your child for routine medical care?

Name: _____ Phone Number: _____

Does your child take any medication? ☐ Yes ☐ No If yes, list medications: _____

Does your child require any special health treatments or procedures (e.g. tube feeding or catheterization)? ☐ Yes ☐ No

If yes, describe: _____

_____

Where do you usually take your child for routine dental care? _____

Name: _____ Phone Number: _____

To the best of your knowledge, has your child had any of the following?

	Yes	No	If yes, describe:
Prematurity			
Birth defect			
Immunity problems			
Bleeding problems			
Lead poisoning			
Sickle Cell Disease			
Diabetes			
Anaphylaxis			
Seasonal allergies			
Food allergies			
Mental health/emotional problems like depression			
ADHD/ADD			
Concussion or traumatic brain injury			
Migraines			
Learning problems/disabilities			
Seizures			
Speech problems			
Ear or hearing problems			
Eye or vision problems			
Dental problems			
Asthma or breathing problems			
Heart problems			
Stomach problems			
Bowel problems			
Bladder problems			
Musculoskeletal problem (including cerebral palsy)			
Limited physical activity			
Other:			

Hospitalization: (please list all) Date(s)	Reason(s)
Surgery: (please list all) Dates(s)	Reason(s)

Parent Signature: _____ **Telephone:** _____ **Date:** _____

Parent Address: _____