

**BROOKFIELD CENTRAL SCHOOL
STUDENT HEALTH INFORMATION FORM**

Student Name: _____ Grade: _____ Date: _____

List any health conditions such as heart, diabetes, allergies, eye or ear problems, illness, surgery, injury, or had any immunizations.

Please check one: () If no changes, Or see list on back ()

Please check one: () **physical at school** () **physical with private physician:**

Date of physical: _____

Doctor _____

Phone _____

Hospital Choice _____

Phone: _____

Any health conditions:

| | | | |
|--------------------|--|---------------------|-------|
| Heart trouble | _____ | Chicken Pox | _____ |
| Diabetes | _____ | Asthma | _____ |
| Epilepsy | _____ | Surgery (past year) | _____ |
| Anemia | _____ | Illness | _____ |
| Vision Defect | _____ (contacts or glasses – circle one) | | |
| Hearing difficulty | _____ | | |
| Allergies | _____ (seasonal) | | |
| | _____ (medications) | | |
| | _____ (food) | | |

Immunizations during the last school year: _____

Parent/Guardian Signature: _____ Date: _____