BRADFORD COUNTY DISTRICT SCHOOLS and
BRADFORD COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

BLEEDING DISORDER QUESTIONNAIRE/HISTORY

(To be completed by parent)

Name: _____D.O.B. _____ School Yr. _____

PLACE I.D. PHOTO HERE

Parent: _____Primary Phone # _____

Physician _____ Phone _____

Brief Description of condition: _____

_____

_____

Medications: **(Please note that IV medications are not given by school personnel)** _____

_____

Restrictions: **(If your child may not participate in physical education activities, a doctor's note is required)**

_____

_____

First Aid Treatment for Bleeding:

- **Apply Ice to the site**
- **Call 9-1-1 for severe bleeding or parent request**
- **Contact Parent/Guardian**
- **Other:_____**

Please add any additional information you feel is needed to safely care for your child:

_____

_____

Authorization for Health Care Provider and School Nurse to Share Information:
I authorize my child's school nurse to assess my child as regards his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/ Guardian Signature _____Date _____

Notes _____

_____

_____

Signature below indicates that the plan is reviewed and appropriate documentation is complete.

School Nurse Signature _____ Date_____

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