SCHOOL DISTRICT OF UPPER DUBLIN

HEALTH HISTORY

Name of Pupil: _____ School: _____

Address: _____ Telephone: _____

Date of Birth: _____ Place of Birth: _____

Family Physician: _____ Telephone: _____

Family Dentist: _____ Telephone: _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? (Give details)

Allergies	____	Ear Infection	____	Leukemia	____	Tonsillitis	____
Asthma	____	Head Injury	____	Mononucleosis	____	Tuberculosis Contact	____
Blood Disorder	____	Hearing Problem	____	Pneumonia	____	Tumor	____
Broken Bones	____	Heart Condition	____	Repeated Colds	____	Tumor (any kind)	____
Chicken Pox	____	Hernia	____	Seizure Disorder	____	Whooping Cough	____
Kidney Disorder	____	Strep Throat	____				

BIRTH OF CHILD (Please Circle)

Instrument Delivery: yes no Premature: yes no Caesarian Section: yes no

Incubator: yes no Oxygen Therapy at Birth: yes no

INJURIES	DATE	OPERATIONS	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OTHER HISTORY: _____

_____

Is your child currently receiving medical treatment? Yes No Why?_____

_____

Does your child wear glasses, hearing aid, or other appliances? If yes, please describe:_____

_____

Is your child restricted from physical activity? Yes No Describe restriction: _____

_____

Is there anything special you wish to bring to our attention? _____

_____

I HEREBY GRANT PERMISSION FOR THE CERTIFIED SCHOOL NURSE TO CONTACT OUR PHYSICIAN OR DENTIST AS NECESSARY.

_____ _____

Parent Signature Date

TO BE COMPLETED BY PARENT AND RETURNED TO SCHOOL NURSE

01/18