COMMONWEALTH OF PENNSYLVANIA
SCHOOL DISTRICT OF SPRINGFIELD TOWNSHIP
School Health Services

Parents/Guardians,
Please complete this form and return, along with a copy of your child's immunization record, attn. School Nurse at the time of your child's registration.

PARENTAL REPORT OF CONFIDENTIAL HEALTH HISTORY (Please print)

Child's Name____ Birth Date________ Gender ❒M ❒F Present Grade____
(Last) (First) (Middle)

Address____
____

Telephone____

Parents' Names____

Previous School Attended___________________________
Address____
____

Person with whom student lives (if other than parent)____

Immunizations: According to Pennsylvania State Law, students in any grade, Kindergarten through 12th, including all public, private, parochial or nonpublic school in the Commonwealth must show proof of immunization status before they can attend school. The regulations regarding immunization schedules are specific and do not allow for any deviations. If immunizations are not properly spaced, revaccination may be necessary. The only exemptions to the school laws for immunizations are medical reasons, religious beliefs, philosophical/strong moral or ethical conviction. If your child is exempt from immunizations, he or she may be removed from school during an outbreak.

Please check any conditions your child has now or has had in the past:

- ❒ ADD/ADHD
- ❒ Allergies: Environmental, food, insect (bee), medications, latex, other
  Please specify: ____
- ❒ Anemia (include sickle cell)
- ❒ Arthritis/Connective Tissue
- ❒ Asthma/Reactive Airway
- ❒ Behavior/Emotional
- ❒ Bowel/Stomach/Intestinal Problems
- ❒ Blood Problem: Bleeding, Clotting, Blood Disease
- ❒ Brain/Nervous System Problem
- ❒ Cancer/Leukemia
- ❒ Cerebral Palsy
- ❒ Chicken pox Date:______
- ❒ Cystic Fibrosis
- ❒ Dental Problem
- ❒ Developmental Delay
- ❒ Diabetes: Type I or Type II
- ❒ Ear Infections (>2/yr.)
- ❒ Eating Disorder
- ❒ Genetic Disorder
- ❒ Head Injury/Concussion
- ❒ Heart Condition/Murmur
- ❒ Hearing Impaired Hearing Aid: ❒ No ❒ Yes
- ❒ High Blood Pressure
- ❒ Migraine Headaches
- ❒ Muscle, Bone, Joint Problem
- ❒ Seizure, epilepsy, convulsions
- ❒ Sleep Disturbance
- ❒ Skin Problem
- ❒ Speech Problem
- ❒ Spina Bifida
- ❒ Urinary/Kidney Disease
- ❒ Visually Impaired Glasses/Contacts: ❒ No ❒ Yes
- ❒ Other (please list): ____

Please fully explain any items checked above:
____
____

Were there any issues during pregnancy, labor and/or delivery for this child? ❒ No ❒ Yes____________________

Has your child ever been a **patient in a hospital** (other than a few days after birth)? ❒ No ❒ Yes If yes, please explain____
____

PLEASE TURN OVER TO CONTINUE------>

Child's Name____

Medication History:

1. Medications given **daily** and why:____
2. Medications given frequently**, but not daily**, and why:____

Note: If your child requires <u>any</u> medication, including over the counter and asthma rescue medications, while at school a medication form signed by the doctor and the parent needs to be on file in the school nurse's office.

Injuries/Surgeries:

	Injuries/Surgeries	Age of Child
1.	________________________	____________
2.	________________________	____________
3.	________________________	____________

Special Needs:

1. Does your child have any physical limitations? ❒ No ❒ Yes ____
2. Will your child need to have medication administered at school? ❒ No ❒ Yes If Yes, contact the school to obtain the proper paperwork and discuss school procedure.
3. Does your child have special considerations/medical needs while in school? ❒ No ❒ Yes
   If yes, please explain____

Current Health:

1. When was your child's most recent physical exam?_________ Significant findings________________________
2. When was your child's most recent dental exam?_________ Significant findings__________________________
3. When was your child's most recent eye exam?_________ Significant findings_____________________________
   Date started wearing glasses, if applicable____________
4. Is your child currently under doctor's care for any medical condition? ❒ No ❒ Yes
   If yes, please explain____
5. Has your child had a recent diagnosis of or exposure to communicable diseases? If yes, please specify_________
6. Was your child born outside the United States? ❒ No ❒ Yes If yes, please specify which country________________________________
7. Has your child traveled outside the United States for a time period of $\geq$ 90 days? ❒ No ❒ Yes If yes, please specify country__________________________
8. Check any of the following to indicate your child's health coverage:
   ❒ Dental Insurance ❒ Vision
   ❒ Medical Insurance ❒ None
   ❒ Private ❒ Medicaid ❒ CHIP ❒ Other
9. Has anyone in your family had a serious illness, newly diagnosed chronic illness, or exposure to contagious diseases? ❒ No ❒ Yes If yes, please specify____

Please list any other information or concerns about your child's physical or emotional health, growth and development, behavior, or family circumstances that you feel the school nurse should know:

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Thank you for this information which will help us provide the best care we can for your child. This information will remain confidential and only be shared with school personnel as deemed appropriate for their educational experience.

____ ________________________

Signature of Parent or Guardian Date

Revised 1/7/2016