

**HEMPFIELD SCHOOL DISTRICT
LANDISVILLE, PENNSYLVANIA
HEALTH HISTORY**

Student's Name: _____
Last
First
Middle
Date of Birth

Medications taken at home (name and dose): _____

Significant Medical Conditions

	Yes	No	If Yes, explain
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are there any special medical problems or chronic diseases, which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Emotional / Behavioral History (Note special problems / age of occurrence):

- Anger
 Depression
 Wetting/Soiling
 Eating Disorder
 Other (Specify) _____

Learning Disability Yes No (If Yes, explain) _____

Speech Difficulty Yes No (If Yes, explain) _____

Hospitalizations/Operations (reasons/dates) _____

- I prefer our family physician to examine my child Yes No
 I prefer the school physician to examine my child Yes No

Parent Signature: _____ **Date:** _____

Name _____ Birthdate _____

Address _____ Parent or Guardian _____

Telephone _____

Race/Ethnicity: White Black Asian or Pacific Islander American Indian or Alaskan Native

Hispanic Origin: Yes No

Please Circle Present Grade K 1 2 3 4 5 6 7 8 9 10 11 12 Other ____

PENNSYLVANIA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION

VACCINE Circle appropriate item	Enter Month, Day, and Year Each Immunization Was Given				
	DOSES				
Diphtheria and Tetanus (DTaP, DTP, Td, or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, Diphtheria and Acellular Pertussis (Tdap)*	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles – Mumps – Rubella (MMR)	1 / /	2 / /	Or Measles Serology Date Titer		
Varicella (Vaccine or Disease)	1 / /	2 / /	Rubella Serology Date Titer		
Meningococcal (MCV)*	1 / /	2 / /	Mumps disease diagnosed by physician: Date		
Other	1 / /	2 / /			

* Age appropriate dose of MCS and Tdap are required for entry into 7th grade.