

SCHOOL DISTRICT OF UPPER DUBLIN ~ HEALTH HISTORY

Name of Pupil _____ School _____

Address _____ Telephone No. _____

Date of Birth _____ Birth Place _____

Father's Name _____ Mother's Name _____

Family Physician _____ Telephone No. _____

Family Dentist _____ Telephone No. _____

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

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

BIRTH OF CHILD (Please circle)

Instrument Delivery	Yes	No	Premature	Yes	No
Cesarean Section	Yes	No	Incubator	Yes	No
Oxygen Therapy At Birth	Yes	No			

Did this child's mother ever have German Measles or any other serious illness during pregnancy? Yes No

(Give details if yes) _____

<u>INJURIES</u>	<u>DATE</u>	<u>OPERATIONS</u>	<u>DATE</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OTHER HISTORY

Is your child receiving medical treatment at present? Yes No Why? _____

Does your child wear glasses, hearing aid, or other appliances? _____

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

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

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

Parent's Signature

TO BE COMPLETED BY PARENT AND RETURNED TO NURSE