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	☐	☐	______
Asthma	☐	☐	______
Cardiac	☐	☐	______
Chemical Dependency	☐	☐	______
Drugs	☐	☐	______
Alcohol	☐	☐	______
Diabetes	☐	☐	______
Gastrointestinal Disorder	☐	☐	______
Hearing Disorder	☐	☐	______
Hypertension	☐	☐	______
Neuromuscular Disorder	☐	☐	______
Orthopedic Condition	☐	☐	______
Respiratory Illness	☐	☐	______
Seizure Disorder	☐	☐	______
Skin Disorder	☐	☐	______
Vision Disorder	☐	☐	______
Other (Specify).	☐	☐	______

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:** ____________

(over) Revised 2/09

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.

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