

THE SCHOOL DISTRICT OF PHILADELPHIA
STUDENT MEDICAL HISTORY

Name of Student	Date of Birth	Date
Name of School	Room/Book/Section	Grade

Dear Parent/Guardian:

Pennsylvania law requires that all children must have a complete checkup when entering school for the first time and again in middle and high school.

The school nurse can help you with information regarding health insurance. There are free and low-cost insurance plans for which your family may qualify. Please take the attached form to your doctor or clinic when you take your child for this checkup and return the completed form to the school nurse by _____

School Nurse: _____

STUDENT'S MEDICAL HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

1. Do you have health insurance? Yes No What is the name of your insurance? _____
2. Where do you take your child for checkups? _____ Phone: _____ Fax: _____
3. Date of child's last physical examination? _____
4. Where do you take your child for dental care? _____ Phone: _____ Fax: _____
5. Date of child's last dental examination? _____
6. Does your child take any medicine now? Yes No, If yes, list below:
 - Medicine: _____ How often _____ For what _____
 - Medicine: _____ How often _____ For what _____
 - Medicine: _____ How often _____ For what _____
7. Is your child allergic to anything? Yes No, If yes, to what _____
8. Does your child have any activity restrictions? Yes No, If yes, explain _____

PLEASE CHECK ANY PROBLEM YOUR CHILD HAS/HAS HAD

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dental | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hospitalized (Surgery) | <input type="checkbox"/> Premature Birth (Under 5 Lbs) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug/Alcohol | <input type="checkbox"/> Learning Problem | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Behavior/Emotional | <input type="checkbox"/> Eczema | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Speech Difficulty |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Chicken Pox at age _____ | <input type="checkbox"/> Heart | <input type="checkbox"/> Muscle/Bone/Joint | <input type="checkbox"/> Urinating/Kidney Problem |

Additional comments: _____

