2/12

HEALTH HISTORY

Greensburg Salem School District ❒ 1 Academy Hill Place ❒ Greensburg, PA 15601

PARENTS: PLEASE FILL OUT BOTH SIDES OF THIS FORM

When completed, please return this form to your child's homeroom teacher as soon as possible.

TO PARENTS OR GUARDIAN: The information requested on this form will be of help to school authorities in determining the health status of your child and in assisting him to receive maximum benefits from his educational opportunities.

School ______________________ Teacher ______________________ Grade __________

Name of child: ______________________________ Address: ______________________________

Birth date: ______________________________ ______________________________

Father's name: ______________________________ Mother's full name: ______________________________

Has your child had any of the followng? Give details.

Yes	No		Yes	No	
❒	❒	Allergy ____________	❒	❒	Seizure Disorder ____________
❒	❒	Operation (Note type) ____________	❒	❒	Emotional Problems ____________
❒	❒	Chicken Pox: Month______ Year ______	❒	❒	Orthopedic Problems ____________
❒	❒	Diabetes ____________	❒	❒	Serious Accidents ____________
❒	❒	Asthma ____________	❒	❒	Chronic Ear Infections ____________
❒	❒	Heart Problems ____________	❒	❒	Tubes in Ears ____________
❒	❒	Attention Deficit Disorder ____________	❒	❒	Birth Defects ____________

❒ ❒ Is your child taking any medications on a regular basis?

If yes, list name(s) of Drug(s) and how often:

Date: ____________ Signature of parent or guardian: ______________________________

Home telephone number: ______________________________

GENERAL INFORMATION

You are encouraged to have the school health examination performed by your family physician. The school nurse will provide the proper forms which are to be completed by your family physician and returned promptly; if the physical form is not returned, signed by your doctor, the physical exam will be done by the school doctor.

PLEASE FILL OUT BOTH SIDES OF THIS FORM (OVER)

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Occupation of father: ____________________ Employed by: __________________________ Phone: _______________

Occupation of mother: ____________________ Employed by : _________________________ Phone: _______________

Name of child's Physician or other source of medical care: ____

Do you want your child taken to Westmoreland Hospital
Emergency Room if parent or physician cannot be contacted? ❐ Yes ❐ No

Names of children: now living at home	Age	Grade	School	If employed, give occupation

If your child just entered our school, give name and address of school from which he/she came:

Please list any other information that the school nurse should be aware of:

Comments: