SOUTHERN YORK COUNTY SCHOOL DISTRICT ELEMENTARY SCHOOLS
MEDICAL HEALTH HISTORY

Please complete this form and return it to school. If all the information is not available at this time, answer as many questions as you can, and send the additional information to the school later.

Name of Student: Last First Middle	Birth date: Month Day Year	Male _____ Female _____
Address of Student: Phone #	Name of Student's Physician or other source of medical care: Address: Phone #	
Father's or Guardian's Name (in present household) (Last/ First/ Middle)	Mother's or Guardian's Name (in present household) (Last/First/Middle)	

Person with whom student lives (if other than parents): Explain relationship:

Brothers and Sisters in household:

Names	Birth dates

Name of student's dentist: Address of Dentist:

Does student visit dentist regularly? Is the child receiving any special dental treatment? Please explain:

Please check if your child has had any of the following operations. Give date if possible.

_____ Appendix removed
_____ Myringotomy (ear operation)
_____ Heart surgery (explain)
_____ Tonsils removed
_____ Tubes in ears
_____ Plastic surgery (explain)
_____ Adenoids removed
_____ Hernia repaired (location)
_____ Other

Please check if your child has had any of the following: Give date if possible

_____ Mumps
_____ Polio
_____ Other
_____ Strep Throat
_____ Chicken Pox Date____
_____ German Measles or 3 day measles
_____ Whooping Cough
_____ Rheumatic Fever
_____ Ear Infections
_____ Has your child had the Varicella Vaccine? (Chicken Pox Vaccine)
_____ Measles - 10 day
_____ Scarlet Fever
_____ Meningitis

IF THE ANSWER IS "YES", YOUR PHYSICIAN MUST VERIFY THE DATE THAT THE VACCINE WAS GIVEN.

Weight of student at birth: _____ lbs. _____ oz. Were there any defects? If yes, please explain:

Is there any evidence of the above birth defect present now?

Did the student appear to develop normally during preschool years? If no, please explain:

Has the student had any operations, serious illnesses, or been hospitalized within the past year? If yes, please explain:

Is the student taking medication regularly? _____ No _____ Yes _____ at home _____ at school
If yes, please give the name of medication and state time it is given, what the medication is for, and the name of the physician prescribing the medication:

Does the student need emergency medication while in school for any of the following?

	No	Yes
Bee/Wasp String	_____	_____
Asthma	_____	_____
Other (Specify)	_____	_____

If you answered yes to the questions about medication being given at school regularly or in an emergency at school, specific forms will be sent home with the student. Sign and return the forms to school. **Physician's orders must be renewed each year.**

Does your child have any other conditions, which should be known to school personnel? _____ No _____ Yes
If yes, please explain:

_____

Has your child ever had any of the following conditions? If the answer is yes, please explain as much as possible so the school might better understand any potential health problems which occur during school hours.

		No	Yes	Explain
1.	Hearing problems			
2.	Wears hearing aid(s)			
3.	Vision problems			
4.	Wears eye glasses			
5.	Epilepsy			
6.	Other seizures or conditions			
7.	Heart condition			
8.	Frequent or severe nose bleeds			
9.	Cerebral Palsy			
10.	Poor physical condition			
11.	Cleft palate and/or cleft lip			
12.	Absence of fingers			
13.	Absence of toes			
14.	Other orthopedic condition or deformity			
15.	Bee or insect sting allergy			
16.	Extreme nervousness or hyperactive			
17.	Other emotional problems			
18.	Stomach ulcer or digestive tract problem			
19.	Asthma			
20.	Other allergies			
21.	Recurring illness			
22.	Any restrictions on physical activity			
23.	Leukemia			
24.	Anemia			
25.	Diabetes			
26.	Kidney disease or problems			
27.	Urinary tract disease or problems			
28.	Tumors (where)			
29.	Cysts (where)			
30.	Hernia/rupture (where)			
31.	Speech problem			
32.	Broken bones (location on body)			
33.	Concussion or head injury			
34.	Severe burns (location on body)			
35.	Severe cuts (location on body)			
36.	Other serious accidents			

_____ _____

Signature of Parent or Guardian Date