HARRISBURG SCHOOL DISTRICT
DEPARTMENT OF SCHOOL HEALTH SERVICES
HEALTH HISTORY

School______________________________ Grade__________ Room__________

To Parent or Guardian: The health information requested here will aid the school authorities in assuring your child maximum benefits from educational opportunities. This is to be updated yearly with another form sent home by the school nurse.

Name of Child______________________________ Date of Birth__________ Sex__________
Last First Middle

Address______________________________ Telephone # Home__________ Work__________

Previous School____________________ Address______________________________

Parent's (Guardian's) Name______________________________

LIST SIBLINGS' NAMES:

1. ____________________ 4. ____________________
2. ____________________ 5. ____________________
3. ____________________ 6. ____________________

Give dates your child received the following immunizations.
(Written proof from physician or clinic required for K5 through 12th grade.)

DOSES DPT	OPV	TD	HEP. B	MMR	HIB	OTHER
1.						
2.						
3.						
4.						
Booster						
Booster						

____
Signature of Interviewer (not initials)

Date____________________

Tuberculin Skin Test (give type) _______ Date_______ Reaction____________________

Has she/he had an X-ray of the chest? No_______ Yes_______ Year_______

Has he/she received TB medication?_______ If yes, when?_______

Please tell us if your child has or has had any of the following

Anemia	_____	Heart Trouble	_____	Sore throats-frequent	_____
Asthma or wheezing	_____	Hives (swellings)	_____	Sugar Diabetes	_____
Bed Wetting	_____	Kidney Trouble	_____	Rheumatic Fever	_____
Fever (extreme, high)	_____	Pneumonia	_____	Rupture-hernia	_____
Eczema (skin rashes)	_____	Seizures, Convulsions or Spells	_____	Chicken Pox	_____
Eye Trouble	_____			Tuberculosis	_____
Hay Fever (watery, red eyes)	_____	Sickle Cell Trait or Disease	_____	Hepatitis, HIV+	_____

Give details of: Food Allergies __________

Allergies to Medicines (which ones?)____________________ Other Allergies __________

Emotional Problems______________________________

Operations______________________________

Recurring or Serious Illness______________________________

Serious Accident/Injury______________________________

Hospitalizations______________________________

Is your child under medical treatment now?_______ If yes, describe below.

Does your child take medication? Yes_______ No_______ If yes, what?____________________

(Medications will be administered at school only according to current school policies.)

COMMENTS:______________________________

Family History: Check ( ) any of the following diseases that parents, grandparents, aunts, uncles, brothers or sisters may have had. (Indicate who.)

Allergy ______________________

Asthma ______________________

Diabetes ______________________

Heart Disease ______________________

Seizures ______________________

Tuberculosis ______________________

Sickle Cell Trait or Disease ______________________

HIV or AIDS ______________________

Check ( ) if your child is being seen at

Harrisburg Hospital ____

Polyclinic Medical Center ____

State Health Center ____

Hamilton Health Center ____

(which site ? Fulton St.
Walnut St.
S.B.H.C.)

Primary Care Provider (M.D.)

____
Name

Dental Provider

____
Name

Are there any problems or other matters which you would like to discuss with the school staff (physician, teacher, nurse, other?)______________________

List any health problem, physical handicap or any limitation of physical activities which should be known to the school.______________________

Remarks______________________

PHYSICAL EXAMINATIONS

Please sign after reading COMPLETELY.

A physical examination and tuberculosis testing are required by the state when your child enters school for the first time. A physical examination is also required by the state in sixth and eleventh grades.

The Harrisburg School District Medical Department requests that your primary care provider (family doctor) do the exam. However, if the examination is not completed before the school nurse begins the school physicals, your child will be included in the school examinations.

Forms will be sent home periodically, reminding you of the need for the physical exam. A form will also be sent requesting your signature as recognition that the exam will be done at school. The approximate date and time will be listed. You are encouraged to be present for the school examination.

Parent/Guardian Signature______________________ Date______________

JLS/ms
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