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_____

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		Chicken Pox	_____
Eye Trouble	_____	or Spells	_____	Tuberculosis	_____
Hay Fever (watery,		Sickle Cell Trait or		Hepatitis,	_____
red eyes)	_____	Disease	_____	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 _____ Seizures _____
Asthma _____ Tuberculosis _____
Diabetes _____ Sickle Cell Trait or Disease _____
Heart 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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