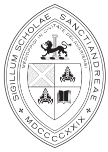

CONFIDENTIAL MEDICAL HISTORY RECORD (New Students)

This confidential information is strictly for the use of the Health Center in providing necessary health care while your son/daughter is a student at St. Andrew's School. This is to be filled out by the student and parent, and reviewed by your physician.

Student Name: ______________________________ **DOB:** ______________

Family History: Have family members ever had any of the following:

☐ Diabetes	☐ Epilepsy/Seizures	☐ Arthritis
☐ Gastrointestinal Disease	☐ Mental Health	☐ Asthma
☐ Kidney Disease	☐ Heart Disease	☐ Allergies/Hay Fever

On the lines below, please explain the relationship to the student for these conditions (or other conditions). ______________________

____

____

Personal History: All questions must be answered.

Please comment on all "yes" answers in space provided or on an additional sheet.

	YES	NO	EXPLANATION/DATE
Have you had headaches or migraines?	☐	☐	______
Do you currently have dental braces, bridges or plates?	☐	☐	______
Have you had rheumatic fever?	☐	☐	______
Have you had ulcers, colitis, irritable bowel syndrome or stomach aches?	☐	☐	______
Have you ever had urinary tract infections, kidney disease or bedwetting?	☐	☐	______
Have you ever had problems with sleeping?	☐	☐	______
Are you ever tearful or sad? (If yes, what causes it?)	☐	☐	______
Have you ever been treated for emotional problems, depression or anxiety?	☐	☐	______
Have you ever been tested or diagnosed with ADD, ADHD or other learning differences?	☐	☐	______
Do you take medication for ADD, ADHD or other learning differences?	☐	☐	______

List the things that cause you stress. ______________________________

What other information can you provide about your child that would be helpful/useful for the Health Center to know in order to treat him/her? ______________________________

____

I certify that all information submitted on this form is factually accurate and honestly presented.

➡ **X** ______________________________ ______________
SIGNATURE OF PARENT/GUARDIAN DATE

➡ **X** ______________________________ ______________
SIGNATURE OF STUDENT DATE

Immunization History

All **new** and **transfer** students **must meet** the following immunization requirements for school attendance according to the Delaware Division of Public Health:

- 1 dose of **Tdap Vaccine**
- 3 or more doses of **DTP** or **DTaP** or **DT Vaccine**
- 3 or 4 doses of **Polio Vaccine** (last dose after the 4th birthday)
- 2 doses of **MMR (Measles, Mumps, Rubella) Vaccine** (or equivalent)
  (1st dose given 12 months of age or later;
  2nd dose given at least 1 month after 1st dose)
- 3 doses of **Hepatitis B Vaccine**
- 2 doses of **Varicella Vaccine** (unless provider documented history of chicken pox or titers)
- 1 dose of **Meningococcal Vaccine**

Recommended (not required)

- 2 doses of **Hepatitis A Vaccine**
- 2 doses of **Meningococcal Vaccine (ACWY)**
- 2 or 3 doses of **HPV (Human Papillomavirus) Vaccine** (dependent on administration of 1st dose)

Please provide a copy of the student's immunization record from their doctor's office, which should include the month, day and year that the student received their vaccines.

Please be sure that the student has received ALL immunizations (as listed above) as REQUIRED by the State of Delaware Division of Public Health.