TRINITY AREA SCHOOL DISTRICT
HEALTH SERVICES
SCHOOL ENTRANCE/HEALTH HISTORY

STUDENT'S NAME ____
Last First Middle

BIRTHDAY ______________________ Sex M / F GRADE ___________________
mm/dd/year

MOTHER'S NAME ____
Last First Middle

FATHER'S NAME ____
Last First Middle

ADDRESS ____
Street City State Zip Code

PERSON(S) WITH WHOM STUDENT LIVES ____

CONTACT NUMBERS

Home: _____________________________ Cell: _______________________________________

Cell: _______________________________ Emergency Contact: __________________________

Siblings (within Trinity Area School District)

NAME	SCHOOL	GRADE
1.		
2.		
3.		
4.		

FAMILY PHYSICIAN ____

HAS STUDENT EVER ATTENDED TRINITY AREA SCHOOL DISTRICT? ____________________

IF YES, WHEN _________________ WHICH SCHOOL ___________________________________

IF TRANSFER STUDENT, NAME OF LAST SCHOOL ATTENDED _________________________

____
City State Zip Code

Pennsylvania state law requires a physical examination and dental examination upon original entry (Kindergarten or Grade 1) and any new student who was previously enrolled in another state. These examinations are provided ***FREE OF CHARGE*** by the school physician and school dentist during school hours. If you do not wish to have the school physician or dentist perform the exam you may have your own physician and/or dentist complete the exams at your own expense. Forms for these examinations can be obtained from the nurse's office.

_______ I permit the school physician to complete the required physical.
_______ I prefer my own physician to perform the exam.
_______ I permit the school dentist to complete the required dental exam.
_______ I prefer my own dentist to perform the exam.

Parent/Guardian Signature ____

OVER →

A. MEDICAL HISTORY: *Check any that apply to your child and list date of onset. If any condition is checked you may use the other (specify)box to further explain.*

Condition	Y/N	Condition	Y/N	Condition	Y/N
ADHD/ADD	Y/N	DEVELOPMENTAL DISORDER	Y/N	MENTAL HEALTH PROBLEMS/CONCERNS: ***please circle*** MEDICATIONS THERAPY OTHER (SPECIFY):	Y/N
ARTHRITIS	Y/N	DIABETES	Y/N		
ANEMIA	Y/N	DISFIGUREMENT: CONGENITAL/ACCIDENTAL	Y/N		
ASTHMA : ***TRIGGERS:*** ***please circle*** ALLERGIES EXERCISE INFECTION WEATHER	Y/N	DIETARY RESTRICTIONS: *IF YES, WHAT RESTRICTIONS*	Y/N	SKIN DISORDER	Y/N
AUTOIMMUNE DEFICIENCY	Y/N	EAR INFECTIONS/TUBES?	Y/N	SPEECH DIFFICULTY	Y/N
		EATING DISORDER	Y/N	STREP THROAT	Y/N
BLEEDING DISORDER	Y/N	FAINTING SPELLS	Y/N	TB EXPOSURE	Y/N
BLADDER CONTROL	Y/N	FREQUENT NOSEBLEEDS	Y/N	THYROID CONDITION	Y/N
BOWEL CONTROL	Y/N	HEADACHES/MIGRAINES	Y/N	VISION DEFICIT: ***please circle*** SEVERE VISION LOSS EYE SURGERY GLASSES/CONTACTS COLOR DEFICIT	Y/N
CANCER	Y/N	HEAD INJURY/CONCUSSION	Y/N		
CHICKEN POX	Y/N	HEARING DEFICIT	Y/N		
CYSTIC FIBROSIS	Y/N	HEART CONDITION: ***please circle*** MURMUR CONGENITAL HEART DEFECT	Y/N		
CONGENITAL CONDITION	Y/N			OTHER (SPECIFY):	
CONNECTIVE TISSUE DISORDER	Y/N				
CONVULSION/SEIZURE DISORDER Type:	Y/N	HIGH BLOOD PRESSURE	Y/N		
		KIDNEY CONDITION	Y/N		
		LUNG CONDITION	Y/N		
		NEUROMUSCULAR DISORDER	Y/N		
DENTAL PROBLEMS	Y/N	ORTHOPEDIC CONDITION	Y/N		

B. ALLERGIES: FOODS _________________________ MEDICATION _________________________
ENVIRONMENTAL ___________________________ INSECT/BEE STING ____________________
OTHER ____
Please describe allergic reaction and treatment: ____

C. IS MEDICATION NEEDED FOR ALLERGY?
AT HOME? Y/N NAME OF MEDICATION ____
AT SCHOOL? Y/N (if yes, please complete form ***No. 210-AR, Medications at School***)

IS MEDICATION NEEDED FOR ANY OTHER CONDITION?
AT HOME? Y/N NAME OF MEDICATION ____
AT SCHOOL? Y/N (if yes, please complete form ***No. 210-AR, Medications at School***)

D. LIST MAJOR OPERATIONS, INJURIES OR HOSPITALIZATIONS (GIVE DATES):
____
____

E. IS THERE ANY ADDITIONAL INFORMATION CONCERNING YOUR CHILD WHICH WILL HELP THE SCHOOL NURSE TO GAIN A BETTER UNDERSTANDING OF YOUR CHILD'S PERSONAL HEALTH CARE NEEDS? ____
____

I UNDERSTAND AND AGREE THAT ANY MEDICAL INFORMATION MAY BE SHARED WITH APPROPRIATE SCHOOL AND MEDICAL PERSONNEL.

PARENT/GUARDIAN SIGNATURE ______________________________ DATE __________