SOUDERTON AREA SCHOOL DISTRICT HEALTH HISTORY

Student's Name _____ _____ _____
Last First Middle

Date of Birth_____ Gender _____

Parent/Guardian	Parent/Guardian
Name:	**Name:**
Cell phone:	**Cell phone:**
Work phone:	**Work phone:**
Home phone:	**Home phone:**
E-mail address:	**E-mail address:**

If your child has had any of the following, give dates and explanation in the "more information" section below:

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Asthma / Wheezing
- ☐ Bronchitis / Pneumonia
- ☐ ADHD
- ☐ Strep Infection
- ☐ Chicken Pox
- ☐ Hepatitis
- ☐ Heart Problems
- ☐ Broken Bones
- ☐ Head Injuries
- ☐ Removal of Adenoids / Tonsils
- ☐ Eating / Feeding Problems
- ☐ Hospitalizations / Surgeries
- ☐ Vision Correction
- ☐ Convulsions / Seizures / Fainting
- ☐ Ear Infections
- ☐ Scarlet Fever
- ☐ Emotional / Mental Health Problems
- ☐ Whooping Cough
- ☐ Other health conditions

MORE INFORMATION: If you marked any of the above, please provide additional information.

_____

NOTE ANY SERIOUS FAMILY HEALTH HISTORY:

Does your child have any allergies?

No ☐ Yes ☐ If yes, please specify: _____

Does your child take any medications or receive ongoing medical treatment? No ☐ Yes ☐

If yes, please specify: _____

My child may receive the following during school hours from a district nurse:

Tylenol (Generic - No Brand Name) No ☐ Yes ☐ Ibuprofen (Generic - No Brand Name) No ☐ Yes ☐

Family Doctor _____ Phone _____ Date of child's last doctor visit: _____

Family Dentist _____ Phone _____ Date of child's last dentist visit: _____

Listed below are adults whom I authorize Souderton Area School District to contact in the event of a medical issue:

Name	Relationship	Phone Numbers
_____	_____	Home: _____ Cell: _____
_____	_____	Home: _____ Cell: _____

By signing this form, I authorize treatment for my son/daughter for any medical emergency treatment that might arise at a time when I cannot be contacted.

_____ _____
Parent/Guardian Signature Date

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