LOWER MORELAND TOWNSHIP SCHOOL DISTRICT
2551 MURRAY AVENUE, HUNTINGDON VALLEY, PENNSYLVANIA 19006

INITIAL HEALTH HISTORY SCHOOL NURSING SERVICE FORM

Expanding Horizons...
Individualizing Excellence

Child's Name: ________________________________ **Grade:** ________________
Last First

Please check if your child has a history of any of the below:

- ☐ Headaches
- ☐ Vision Problems
- ☐ Fainting
- ☐ Frequent Sore Throats
- ☐ Asthma
- ☐ Allergies, (please list)

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- ☐ Chronic Cough
- ☐ Earaches/Infections
- ☐ Hearing Loss
- ☐ Cardiac Condition
- ☐ Stomach/GI Condition
- ☐ Other

Has your child ever been hospitalized for any reason? If yes, please explain:

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Has your child ever had any surgery? ☐ Yes ☐ No If yes, please describe.

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Is your child currently taking any medications? ☐ Yes ☐ No If yes, please give name of medicine, dose, and times given:

Medicine ________________________ ________________________
Dose ________________________ ________________________
Times ________________________ ________________________

Date: ________________________ Signature: ________________________

1/15/2013