RETURN TO NURSE

CHAMBERSBURG AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
HEALTH HISTORY REVIEW

This request for information is being made to help the Certified School Nurses update your child's School Health Records. We can better monitor the health and safety of our students with up to date health information.
Please circle any condition that pertains to your child, giving any additional information you believe to be significant under "COMMENTS" and return to your school nurse.

STUDENT'S NAME_____GRADE/ROOM_____

1. Allergy (list)
2. Arthritis/Rheumatic Disease
3. Asthma (medication)
4. ADD/ADHD (medication)
5. Birth/Developmental Defects
6. Bleeding Disorders/Anemia
7. Cardiovascular Conditions
8. Connective Tissue Disorders
9. Cystic Fibrosis
10. Diabetes
11. Eating Disorders
12. Endocrine Disorders
13. Gastrointestinal Disorders
14. Genitourinary Disorders
15. Hearing
16. Hypertension
17. Immunity Suppression
18. Cancer
19. Neurologic Disorders
20. Orthopedic Disorders
21. Psychiatric Disorders
22. Seizure Disorders
23. Sickle Cell Disease
24. Vision/Color Defect
25. Weight Disorders
26. Describe any not mentioned here

COMMENTS:

_____
_____
_____
_____
_____
_____

OVER

During this past year, has your child: **CIRCLE ONE**

Had an illness, serious injury or operation? (If yes, please describe) Yes No

_____

_____

Is your child still under treatment? Yes No

If yes, Physician's name_____

Should your child be restricted from participating in school sports? Yes No

Should your child be restricted from participating in gym class? Yes No

If yes, please provide recommendation from your physician in writing.

Does your child require a special diet? Yes No

If yes, please specify_____

Does your child have any allergies that require attention at school? Yes No

If yes, please list specific instructions for allergic reactions. If bee stings are a **MEDICAL EMERGENCY**, request a bee sting form from the school nurse.

_____

_____

Is your child presently taking medication? Yes No

Name of medication_____Dosage_____

Time of Day_____Reason_____

_____

_____

If medication is taken at school, please follow the medication policy or call your school nurse with questions.

Has your child had any immunizations (during the past year)? Yes No

If yes, please give name and date_____

_____

_____

Has your child had any communicable diseases during the past year? Yes No

If yes, please give name, date and treatment (if prescribed)_____

_____

_____

Have there been changes in your family status or any other situations that may affect your child? Yes No

If yes, please explain or call to request a conference with your school nurse or school counselor._____

_____

_____

Thanks for letting us help with your child's health care.

_____ _____

Signature Of Parent/Guardian Date

Health History Review 05/99, 05/01, 09/01