CHARTIERS VALLEY SCHOOL DISTRICT | Inspiring excellence.

CHARTIERS VALLEY SCHOOL DISTRICT HEALTH HISTORY

This history is to be completed by the parent.
A copy of the physician's immunization record must be attached.

STUDENT NAME _____

BIRTHDATE _____ GRADE _____ SEX ☐M ☐F

HOME ADDRESS _____ HOME PHONE _____
Street Zip Code

FATHER'S NAME _____ WORK PHONE _____

MOTHER'S NAME _____ WORK PHONE _____

PARENT E-MAIL ADDRESS _____

PERSON WITH WHOM STUDENT LIVES (if other than parents) _____

STUDENT'S DOCTOR _____ PHONE _____

STUDENT'S DENTIST _____ PHONE _____

MEDICAL HISTORY OF CHILD (Circle all that apply and provide dates):

ADHD/ADD
Asperger's/autism
Bronchitis
Cancer (type)
Cerebral Palsy
Chemical/ Hormonal imbalance
Chicken Pox
Cystic Fibrosis
Diabetes
Drug/Alcohol abuse
Eating disorder
Emotional/ Mood problems
Health disorder
Hypoglycemia
Intestinal disorder
Migraine headaches
Muscular Dystrophy
Scoliosis
Seizure disorder
Spina Bifida
Tourette Syndrome
Other _____

Please provide additional details, if necessary: _____

_____

_____

(Revised 02/2014)

(OVER)

PLEASE PROVIDE DETAILS FOR THE FOLLOWING (IF APPLICABLE).

Asthma: *When was the child diagnosed? What triggers it? Symptoms? Treatment? Medication? Doctor?*

Allergies: *To what? Symptoms? Treatment? Doctor?*

Ear Problems: *What type of problem? Tube in ear? Hearing aid? Which ear? Doctor?*

Vision Problems: *Wears glasses? Type of problem? Doctor? Date of last appointment?*

Recurring Illness:

Operations:

Serious Accidents:

Orthopedic Problems:

List any other illness or health problem which you or your family physician feel should be known to the school nurse:

Medications taken at home:

Medications to be taken at school: (*Please note that there is a strict school policy regarding over-the-counter and prescription medications. Forms must be obtained from the Health Office and completed by parent and physician before any medication can be administered during school hours.*)

Name of last school attended: Grade:

Address of last school attended:

Do you give permission to share this information with your child's teacher and/or counselor? ☐ Yes ☐ No

Would you like a conference with the school nurse? ☐ Yes ☐ No

_____ _____

Parent/Guardian Signature *Date*

(Revised 02/2014)