STATE COLLEGE AREA SCHOOL DISTRICT
Learning Enrichment and Student Services
Health Services

HEALTH HISTORY

To be completed by <u>PARENT/GUARDIAN:</u>

Name of Student ______________________________ Date of Birth_____________ Grade ____

Name of Family Physician ____

1.) Communicable diseases____

a. Chicken Pox: ~ Yes Date: _________________ ~ No

2.) Medical conditions, operations, allergies, illnesses__________________________________

3.) Need for special diet or considerations ____

4.) Is your child under medical treatment at present? __________________________________

If so, for what condition? ____

5.) Note any medication your son/daughter is currently taking .

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6.) Note any special condition you wish to call to the attention of the examining physician.

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GIVE DATE OF MOST RECENT IMMUNIZATION BOOSTER

(MONTH, DAY, YEAR)

Diphtheria.. ____________________

Tetanus... ____________________

Polio.. ____________________

Measles/Mumps/Rubella (MMR).. ____________________

Hepatitis B. 1. _______________________ 2. ___________________ 3. __________________

Varicella Immunization ....____________________

Tuberculin Test Date .... ____________________

Device: Tine ______ Mantoux _________ Result ____________________________