

**SOUDERTON AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
HEALTH HISTORY**

To Parent or Guardian: The information requested on this form will be of help to the school in determining the health status of your child and will help the school in assisting him/her to receive the maximum benefits from the educational opportunities available in our school district. Please complete it **FULLY** and return it **PROMPTLY** to the school nurse.

Pupil's Name _____
Last
First
Middle

School _____

Birthdate _____ Sex _____ Birthplace _____

Father's Name: Last _____ First _____ Middle _____

Mother's Name: Last _____ First _____ Middle _____

Mother's Maiden Name: _____ Home Telephone No. _____

Home Address _____

Person with whom pupil lives, if other than parent:

Last: _____ First _____ Relationship _____

If your child has had any of the following, give dates:

DATE	DATE
Diabetes _____	Heart Problems _____
Hypoglycemia _____	Broken Bones _____
Asthma/Wheezing _____	Head Injuries _____
Bronchitis _____	Removal of Adenoids/Tonsils _____
Pneumonia _____	Eating/Feeding Problems _____
Strep Infection _____	Hospitalizations _____
Scarlet Fever _____	Vision Correction _____
Chicken Pox _____	Convulsions/Seizures/Fainting _____
Hepatitis _____	Ear Infections _____
Whooping Cough _____	Surgeries: _____
Allergies (list) _____	

Please note any complications to the above: _____

NOTE ANY HISTORY OF THE FOLLOWING DISEASES IN THE FAMILY:

Heart Disease (Rheumatic Fever) _____ Diabetes _____ Tuberculosis _____

Vision Problems _____ Epilepsy _____ Asthma _____

Hearing Problems _____ Allergies (list) _____

REMARKS OR RECOMMENDATIONS CONCERNING YOUR CHILD'S HEALTH:

Is your child under medical treatment or on medication: Yes _____ No _____

If yes, give reason or medication: _____

Date of child's last dentist visit: _____

Signature of Parent or Guardian _____ Date _____