

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

COMMENTS:

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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