



CENTENNIAL SCHOOL DISTRICT

433 Centennial Road, Warminster, PA 18974-5448

(215) 441-6000, Extension 11046 FAX: (215) 441-5883

SCHOOL HEALTH SERVICES HISTORY FORM

(To be completed by parent/guardian)

Student Name: _____ Birth Date: _____
Last First Middle

Student's Home School: Davis Elementary McDonald Elementary Willow Dale Elementary
 Klinger Middle School Log College Middle School William Tennent High School

Parent/Guardian Information

Name: _____

Name: _____

Address: _____
Street City State Zip Code

Address: _____
Street City State Zip Code

Home Phone # _____

Home Phone # _____

Work Phone # _____

Work Phone # _____

Mobile Phone # _____

Mobile Phone # _____

E-mail Address: _____

E-mail Address: _____

Physician Information

	Name	Phone Number	Date of Last Exam
Physician			
Dentist			

Health History

Allergies: Check all that apply and give more detailed information.

- Animals _____
- Food _____
- Latex _____
- Other _____
- Environment _____
- Insect bites/stings _____
- Medicine _____

Disease/Disorder or Illness (check all that apply)

- Asthma/Breathing Disorders
- Bleeding/Clotting Disorder
- Convulsions/Epilepsy/Seizure
- Diabetes
- Eating Disorder
- Headaches/Migraines
- Hepatitis or Liver Problem
- Mobility Limitation
- Skin Condition
- Vision or Eye Disorder
- Behavioral Disorder
- Bone/Joint/Muscular Disorder
- Developmental Disorder
- Dietary Restriction
- Endocrine Disorder
- Hearing Problem
- Hypertension
- Psychological/Emotional Problem
- Speech Disorder
- Other (explain)
- Bladder/Kidney/Urinary Disorder
- Cancer
- Dizziness or Fainting
- Digestive/Bowel Disorder
- Head or Spinal Injury
- Heart Defect or Disease
- Immune System Disorder
- Scoliosis
- Surgery or Hospitalization

Under Doctor's Care

(If YES, please add details – An action plan will need to be completed by the doctor to ensure a safe school environment for your child.)

Asthma Yes No

Severe Allergy Yes No

Type 1 Diabetes Yes No

Type 2 Diabetes Yes No

Seizures Yes No

If yes, medications taken: _____

Describe allergic reaction: _____

Was an Epi-pen prescribed? Yes No

Describe type: _____

Medications taken: _____

Medication History

Yes No My child takes medication or supplements on a daily basis including homeopathic and nutritional supplements.

Listing of all medications/supplements:	What this medicine/supplement is used for:

Social History

Have there been any changes in your family during the past year, such as:

Yes No Separation, divorce, and/or remarriage

Yes No Death or serious illness

Yes No Any other situation that may impact your son/daughter? If yes, explain:

Miscellaneous

Please list any condition and/or restrictions that may limit his/her activities.

Not applicable

Yes Condition/restriction: _____ Comments/explanation: _____

Consent to Share Information

The school nurse and/or health aide has my permission to share my child's confidential health information, on a need-to-know basis, with appropriate members of the educational staff and primary healthcare providers for use in meeting the educational and health needs of my student. The consent includes the sharing of personally identifiable health record information during immunization and communicable disease surveillance.

Parent/Guardian Signature: _____ Date: _____