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: _____
Address: _____
Street City State Zip Code
Home Phone # _____
Work Phone # _____
Mobile Phone # _____
E-mail Address: _____

Name: _____
Address: _____
Street City State Zip Code
Home Phone # _____
Work Phone # _____
Mobile Phone # _____
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
☐ Chicken Pox
☐ Dizziness or Fainting
☐ Digestive/Bowel Disorder
☐ Head or Spinal Injury
☐ Heart Defect or Disease
☐ Immune System Disorder
☐ Scoliosis
☐ Surgery or Hospitalization
☐ Behavioral Disorder
☐ Bone/Joint/Muscular Disorder
☐ Convulsions/Epilepsy/Seizure
☐ Diabetes
☐ Eating Disorder
☐ Headaches/Migraines
☐ Hepatitis or Liver Problem
☐ Mobility Limitation
☐ Skin Condition
☐ Vision or Eye Disorder
☐ Bladder/Kidney/Urinary Disorder
☐ Cancer
☐ Developmental Disorder
☐ Dietary Restriction
☐ Endocrine Disorder
☐ Hearing Problem
☐ Hypertension
☐ Psychological/Emotional Problem
☐ Speech Disorder
☐ Other (explain)

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	If yes, medications taken:
Severe Allergy	☐ Yes	☐ No	Describe allergic reaction: _____ Was an Epi-pen prescribed? ☐ Yes ☐ No
Type 1 Diabetes	☐ Yes	☐ No	
Type 2 Diabetes	☐ Yes	☐ No	
Seizures	☐ 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: _____