Penn Cambria School District- Student Health History

(This information will become a part of your child's confidential school health record.)

Student's Full Name______ Sex _____ Grade_____

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:

Items with an asterisk (*) require and additional form. This form will be provided by the nurse.

Health Condition	No	Yes	Explanation if "Yes"
Please check yes or no			Please circle additional information that pertains to your child.
Arthritis/Rheumatic Disease			
*Asthma			Rate the severity (please circle):MildModerateSevereLife ThreateningMedication taken at home:Medication required at school:Other info:
Attention			Medication take at home:
Deficit/Hyperactivity Disorder			Medication take at school:
*Bee Sting Allergy			Rate the reaction: Mild Moderate Severe Life Threatening Does your child require Benadryl? No Yes EpiPen? No Yes
Bleeding Disorder/Cooley's			
anemia			
Cancer			Specify: Treatment:
Cardiovascular Condition (Heart)			
Cerebral Palsy			
Congenital abnormality/Birth Defect			
Cystic Fibrosis			
*Diabetes			Type I (Insulin dependent) Type 2 Diabetes Medication:
Drug Allergies			
Environmental/Seasonal			
Allergies			
*Epilepsy/Seizure Disorder			Type of Seizure: Seizure Medication: Does your child require Diastat or Nasal Midazolam? No Yes
Eye or Vision Problems			Diagnosis: Glasses Contacts for distance for reading
*Food Allergy			Food(s):Rate the reaction: mildmoderateseverelife threateningDoes your child require Benadryl? NoYesEpiPen? NoYes
Gastrointestinal Disorder (Bowel/Digestive Issues)			Specify: Medications: Special Diet:
Headaches			Migraines: No Yes Triggers: Treatment:
Hearing Loss			Right ear Hearing aids Tubes
Kidney/Bladder Problems			-
Language/Speech Difficulties			
Mental/Emotional/Behavioral			Specify:
Health			Treatment/Medications:
*Other Allergy			List & Explain severity: Does your child require Benadryl? No Yes EpiPen? No Yes
Sickle Cell Disease			
Skin Problems/Eczema			
Spina Bifida			
Tourette's Syndrome			

Has your child ever had a concussion, loss of consciousness, serious fall or head injury? If yes, when:				
Please explain:				
Has your child had a serious illness, injury, hospitalization or surgery? Describe:				
Is your child restricted from physical activity? (Written restrictions signed by a doctor are required) Describe:				
Any health-related accommodations needed to be made by staff to assist your child's learning and safety? If yes, please explain:				
Is there any other health problems/issues not mentioned which may become apparent at school and which the school nurse, administrators, and teachers should know about?				
Does your child have complete bowel and bladder control?				
Does your child need any accommodations with bathroom needs? If yes, please explain:				
Student's Physician	Phone Number			
Student's Dentist	Phone Number	_		
Please contact the school nurse if there are any changes in your child' receives immunizations so health records can be updated.	s health status. Keep the nurse apprised whe	n your chi	ld	

This information will be shared in a CONFIDENTIAL MANNER with appropriate school personnel as needed in order to provide for your child's educational, health and safety needs.

Parent/Guardian Signature

Printed Name

Date