

**SCHOOL DISTRICT OF CHELTENHAM TOWNSHIP  
STUDENT HEALTH HISTORY**

**THIS FORM SHOULD BE FILLED OUT BY A PARENT OR GUARDIAN**

Your child's success in school rests to a great extent on his/her well-being. The information requested on this form will assure your child has a successful educational experience.

Name: \_\_\_\_\_  
Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Parent/Guardian: Mother: \_\_\_\_\_ Father: \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ Phone# \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ Phone# \_\_\_\_\_  
Person with whom child lives \_\_\_\_\_  
Physicians:  
Primary Care Physician \_\_\_\_\_ Phone# \_\_\_\_\_  
Current Specialty Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Does your child have a health problem? (check where appropriate)

Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_ Vision \_\_\_\_\_ Sickle Cell Anemia \_\_\_\_\_ Injury \_\_\_\_\_  
Anemia \_\_\_\_\_ Hearing \_\_\_\_\_ Seizures/Convulsions \_\_\_\_\_ Heart \_\_\_\_\_  
Explain \_\_\_\_\_

Does your child take medication? \_\_\_\_\_ Name of medication(s) \_\_\_\_\_  
Any allergies to medications or insect stings?( If yes, list on reverse side) \_\_\_\_\_  
Has your child ever had a concussion or been knocked unconscious? \_\_\_\_\_  
Has your child ever had a convulsion or seizure? \_\_\_\_\_  
Does your child wear any removable dental appliance? (retainer, bridge) \_\_\_\_\_  
Does your child wear glasses or contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_ Hearing Aid? Yes \_\_\_\_\_ No \_\_\_\_\_  
Has any family member had sudden death or heart attack before age 50? \_\_\_\_\_  
Has your child had any heart disease, murmur, extra beats, or high blood pressure? \_\_\_\_\_  
Has your child ever been dizzy or passed out from exercise? \_\_\_\_\_  
Does your child have any missing organs (kidney, testicle, eye, etc.) \_\_\_\_\_  
Has your child engaged in any chemical or substance usage? \_\_\_\_\_  
Does your child experience any menstrual irregularities (females)? \_\_\_\_\_  
Has your child ever induced vomiting, or engaged in binge eating or purging? \_\_\_\_\_  
Are there any problems in the home that might affect your child's learning? \_\_\_\_\_

Comments \_\_\_\_\_

Is there anything more about your child's health that you think is important for us to know? \_\_\_\_\_

Explain: \_\_\_\_\_

Allergies: Medications or foods to be avoided \_\_\_\_\_

Reactions \_\_\_\_\_

Additional Data: Birth weight \_\_\_\_\_ Premature \_\_\_\_\_ Normal Birth \_\_\_\_\_

Please describe any birth defects \_\_\_\_\_

Is your child receiving medical treatment at present? Yes \_\_\_\_\_ No \_\_\_\_\_

Is your child restricted from physical activity? Yes \_\_\_\_\_ No \_\_\_\_\_

Describe: \_\_\_\_\_

Is your child receiving treatment at present for a physical or mental ailment? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child had any operations or serious injuries? \_\_\_\_\_

Describe: \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

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Has your child had any operations or serious injuries? \_\_\_\_\_

Describe: \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Student's Name \_\_\_\_\_

Grade \_\_\_\_\_ Date \_\_\_\_\_

Form 186  
6/02

### MEDICATION FOR STUDENTS

The effects of medication may vary with individual students, therefore, it is necessary that written permission be given for all medication, which must be taken in school. Any prescribed medication must come with instructions from the physician.

If you are concerned that your child may need Ibuprofen / Tylenol during the school year, please have your physician sign this card below to authorize the school nurse to administer.

Medication may be taken only in the office under the supervision of the school nurse or an administrator.

Tylenol / Ibuprofen \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_