HEALTH HISTORY – DOVER AREA SCHOOL DISTRICT – DOVER, PA.

To Parents or Guardians: The information requested on these forms will help the school authorities meet the school health needs of your child.

Child's Name _____ Birth Date _____
Last First Middle Sex: Male Female

Birth Certificate Number _____ Place of Birth _____
Father's Name _____ Birthplace _____
Mother's Maiden Name _____ Birthplace _____
Persons with whom child resides _____ Relationship _____

IMMUNIZATION DATES

IMMUNIZATIONS AND TESTS

	DATE ADMINISTERED 1	2	3	4	BOOSTERS AND DATES 5	6
DIPHTHERIA & TETANUS						
POLIO						
MEASLES, MUMPS, RUBELLA						
HEPATITIS B						
VARICELLA						
HIB						
OTHER (SPECIFY)						

EXEMPTIONS

☐ MEDICAL EXEMPTION ON FILE

☐ RELIGIOUS EXEMPTION ON FILE

Note: Immunization dates within bold blocks are required for school enrollment.

	DATE	RESULT	DATE	RESULT
TUBERCULIN TESTS				
CHEST X-RAYS				

STUDENT'S HEALTH HISTORY
(ENTRY)

A. Pre-Natal Health History — Circle the Answer

1. Did the mother have any illness during the pregnancy? ..... NO YES
2. Did the mother take any medications or drugs (other than iron or vitamins) during the pregnancy: ..... NO YES
3. Was the baby born more than 2 weeks early or 2 weeks late? ..... NO YES

If you have circled Yes to any of the above questions, please indicate the reason below

B. Developmental History

1. What was the baby's birth weight? _____
2. Did the baby have any problems while in the hospital? ..... NO YES
3. Did the baby have any special problems in the first 6 months? ..... NO YES
4. At what age did the child sit alone without support? _____
5. At what age did the child walk alone without support? _____
6. At what age did the child begin to say 2 to 3 words together? _____
7. At what age was child toilet trained? _____

If you have circled Yes to any of the above questions, please indicate the reason below.

(Over)

C. Health History (continued)

		Circle the Answer	
1.	Has the child had Measles, German Measles, Whooping Cough?	NO	YES
2.	Has the child had Chicken Pox? Date _____	NO	YES
3.	Has the child had Rheumatic Fever?	NO	YES
4.	Has the child had Pneumonia?	NO	YES
5.	Has the child had more than 6 colds or throat infections with fever, a year?	NO	YES
6.	Has the child's hearing been tested?.....	NO	YES
7.	Has the child's vision been tested?.....	NO	YES
8.	Does your child wear glasses?	NO	YES
9.	Has the child had any trouble with teeth?	NO	YES
10.	Has the child ever had a fainting spell?	NO	YES
11.	Does the child complain of headaches?	NO	YES
12.	Has a doctor ever said the child had a heart murmur?	NO	YES
13.	Does the child have trouble keeping up with other children?	NO	YES
14.	Do any foods disagree with the child?	NO	YES
15.	Does the child often have diarrhea?	NO	YES
16.	Has constipation ever been much of a problem for this child?	NO	YES
17.	Has the child ever had worms or parasites?	NO	YES
18.	Have you ever seen blood in the child's stools?	NO	YES
19.	Has the child ever had jaundice or problem with the liver?	NO	YES
20.	Does the child complain of abdominal pain?	NO	YES
21.	Does the child have any problems with urination?	NO	YES
22.	Does the child have any skin problems?	NO	YES
23.	Has the child ever had asthma or wheezing?	NO	YES
24.	Does the child have trouble breathing through the nose?	NO	YES
25.	Does the child snore at night?	NO	YES
26.	Has the child ever complained of pain in the arms or legs?.....	NO	YES
27.	Has the child ever had swelling of any joints or limping?.....	NO	YES
28.	Has the child ever had a blood disorder?.....	NO	YES
29.	Has the child ever eaten paint or plaster or anything else which is not food?.....	NO	YES
30.	Does the child have any problem sleeping?.....	NO	YES

If you have circled Yes to any of the above questions, please indicate the reason below.

Circle any of the following that concern you about the child:

1. Bedwetting
2. Wetting during the day
3. Thumbsucking
4. Stammering or stuttering
5. High strung or easily upset
6. Shy
7. Sad and sulky
8. Feelings easily hurt
9. Wanting too much attention
10. Wanting too much comfort or support from parent
11. Day dreams
12. Nightmares
13. Temper tantrums
14. Contrary or stubborn
15. Disobedient
16. Lying
17. Selfish in sharing
18. Jealous of brothers and sisters
19. Fighting with other children
20. Purposely destroys things
21. Feeding problems
22. Bowels problems
23. Any other problems not mentioned

_____

_____

_____

D. **Special Health Needs** **Circle the Answer**

Has the child ever had any serious illness or operations? - NO YES
What? _____ Date: _____

Is the child being treated for a health problem now? - NO YES
Type of problem: _____ Date last seen: _____

Other than vitamins, is the child taking any medicine, tablets or drugs? - - - - - - - - - - - - NO YES
What? _____ Reason _____

Does the child need to take any medication at school? - NO YES
What? _____ Reason _____

Is the child allergic to anything, such as foods, plants, insects, medicine? - - - - - - - - - - - NO YES
What? _____

Has the child had any convulsions (seizures)? - NO YES
How many? _____ Treatment _____

Does the child need a special diet or have any food problem? - - - - - - - - - - - - - - - - - - NO YES
Give details _____

Has the child had any other illnesses, accidents, fractures, sutures? - - - - - - - - - - - - - - NO YES
What? _____ When? _____

Does the child have any other special health needs or problems? - - - - - - - - - - - - - - - - NO YES
What? _____

If you have answered Yes to any of the above questions, please use this space to provide more information:

E. Family Health History (Please indicate if maternal or paternal).

Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, sisters, have had:

Allergy, asthma, cancer, drug and alcohol addiction, diabetes, heart disease, seizures, psychiatric problems, tuberculosis, lead poisoning, sickle cell disease, vision problems, hearing problems, learning problems, anemia, other inherited or family diseases.

(Over)

F. State Law requires that every child shall have a physical examination and a dental examination completed within 1 year of the original entrance date into school. If you wish to have the physical exam or dental exam done by the school physician/dentist, please sign below:

School Physical: _____ _____
(Parent Signature) (Date of signature)

School Dental: _____ _____
(Parent Signature) (Date of signature)

Name of Family Dentist _____

Phone No. _____

Name of Family Physician _____

Phone No. _____

Medical Insurance:

Does your child have health insurance coverage? YES NO
If yes, please complete:

Medical Card or Access Card _____
Number

Blue Cross/Blue Shield _____/_____/_____
ID number Group Number Type

Other Insurance _____/_____
Name Number

Is the insurance coverage for your child an HMO policy? YES NO

If your child is covered by an HMO policy, who is the Primary Care Physician:

_____/_____
Name Phone Number

G. Signature of Parent or Guardian _____

Date _____

Address _____

_____

_____

Home Phone _____

Work Phone _____