TULPEHOCKEN AREA SCHOOL DISTRICT
HEALTH HISTORY

To parents or guardian: The information requested on this form will be of help to the school authorities in determining the health status of your child and in assisting him or her to receive maximum benefits from his educational opportunity.

Name of child: Birth Date: (month, day, year) Birth Place: (city, state)

Home Address Telephone number Sex: [ ]male [ ] female

Father's Name: (last, first, middle) Mother's Name: (last, first, middle)

Person with whom the child lives (if other than parent)

Name of child's physician or other source of medical care:

You are encouraged to have the school health examination performed by your family physician. The school authorities will provide the proper forms to be completed by your family physician at your expense. If your child is to be examined by the school physician you will be informed of the date and time of the examination.

Has your child had any of the following? When?

Allergies__________________________ Diabetes___________________________ Asthma_________________

Pneumonia________________________ Chicken Pox________________________ Cerebral Palsy___________

Rheumatic Fever __________________ Epilepsy____________________________ Scarlet Fever___________

Hernia____________________________ Operations or Injuries____

Emotional Problems____

Physical Handicaps____

Is your child under medical treatment at the present time?____

Is your child taking any medications?____

List any illness or health problems, which you or your family physician feels should be known to the school authorities:____

History of birth of child: (Circle yes or no)

Long labor	Yes	No		Instrument delivery	Yes	No
Premature (if yes, # of months __________	Yes	No		Caesarian birth	Yes	No
Placed in incubator	Yes	No		Oxygen given after birth	Yes	No
Breech	Yes	No		Jaundice after birth	Yes	No

Health History: (Circle yes or no)

Does your child have a history of high fever?	Yes	No
Has the child had more than six colds or throat infections, with a fever, a year?	Yes	No
Has the child had any trouble with ears or hearing?	Yes	No

Has the child had any trouble with eyes or seeing?	Yes	No
Has the child had any trouble with teeth?	Yes	No
Has the child ever had a convulsion or fit?	Yes	No
Has the child ever had a fainting spell?	Yes	No
Does the child complain of headaches?	Yes	No
Has the doctor ever said the child had a heart murmur?	Yes	No
Does the child have trouble keeping up with other children?	Yes	No
Do any foods disagree with the child?	Yes	No
Does the child often have diarrhea?	Yes	No
Has constipation ever been much of a problem for this child?	Yes	No
Has the child ever had worms or parasites?	Yes	No
Have you ever seen blood in the child's stool (bowel movement)?	Yes	No
Has the child ever had yellow jaundice or trouble with the liver?	Yes	No
Does your child complain of belly aches?	Yes	No
Does the child have any problem with passing water (urination)?	Yes	No
Does your child have any skin problems?	Yes	No
Has the child ever had eczema or allergy?	Yes	No
Has the child ever had asthma or wheezing?	Yes	No
Has the child ever had an allergy or reaction to any medicines or injections? What was the medicine or injection?	Yes	No

Family History: (Grandparents, parents, brothers or sisters) Please circle and explain.

Tuberculosis, diabetes, heart disease, allergies, asthma, epilepsy, blindness, deafness, kidney condition, nervous breakdown.

Parent/Guardian Signature______________________________________ Date_____________________________