

**Plum Borough School District
Health Services Department**

Health History Information

Student's Name _____ Grade ____ Date of Birth _____

List Allergies (to medications, food, environment, or insects):

Allergic to:	Type of Reaction:	Treatment Required:
_____	_____	_____
_____	_____	_____

List the Student's Current Medications*(include dosage, frequency, and time taken): _____

Current Health Problems: _____

List Previous Hospitalizations and Surgeries: _____

Does the student have a history of:	<u>Yes</u>	<u>No</u>	<u>Explain Yes Answers Here:</u>
Asthma, Pneumonia, Recurrent Cough, Respiratory Illness	_____	_____	_____
Attention Deficit Disorder, Mental or Nervous Disorder	_____	_____	_____
Bone or Muscle Disorders, Previous Orthopedic Injury	_____	_____	_____
Born Prematurely, Developmental or Speech Delay	_____	_____	_____
Cancer, Blood Disorder, Inherited, Genetic Problems	_____	_____	_____
Diabetes, Other Endocrine Disorders	_____	_____	_____
Drug or Alcohol Problems	_____	_____	_____
Ear, Nose, Throat, Vision, Hearing Problems	_____	_____	_____
Gastrointestinal or Urinary Problems	_____	_____	_____
Head Injuries, Seizures, Dizziness, Concussion	_____	_____	_____
Heart Trouble, Murmur, Hole in heart, High blood Pressure	_____	_____	_____
Migraines, Frequent Headaches	_____	_____	_____
Scoliosis (curvature of the spine)	_____	_____	_____
Skin Conditions-Hives, Rashes, Eczema	_____	_____	_____
Do you have any concerns about your child's emotional well-being or behavior?	_____	_____	_____
Any Other Conditions – (not listed above)	_____	_____	_____

Please check if you would like to discuss your child's status with any of the following school personnel:

School Nurse _____ Teacher _____ Guidance Counselor _____ Speech Therapist _____

***Please keep in mind that if medications need to be given during school hours, Pennsylvania State Law requires a physician's order be provided to the school nurse. In addition, pharmacy medications must be in properly labeled safety containers.**

It is important to keep the school nurse informed regarding any changes in medication or any of the above information. Thank you for your cooperation in this matter.

Parent / Guardian Signature _____ Date _____