PENNSBURY SCHOOL DISTRICT
134 Yardley Avenue • Post Office Box 338
Fallsington, Pennsylvania 19058-0338
Telephone (215) 428-4100
FAX: (215) 428-5212

MEDICAL HISTORY REPORT

Student's Name: ______________________ Sex: ______ Birthdate: ______________

Address: ____

Phone Number: ______________________ Grade: ______ School: ______________

Mother's Name: ______________________ Father's Name: ______________________

Number of Brothers: ________ Number of Sisters: ________ This child is ____________ (number) in the family

1. With whom does the student live? ______________________ Relationship to student: ______________________

2. Does your child have a health problem? (check all that are appropriate)

- ❑ Asthma
- ❑ Allergies
- ❑ Anemia
- ❑ ADHD
- ❑ Diabetes
- ❑ Chicken Pox – Date: __________
- ❑ Heart Problem
- ❑ Lung Problem
- ❑ Urinary Problem
- ❑ Orthopedic Problem
- ❑ Gastrointestinal Problem
- ❑ Vision Problem
- ❑ Hearing Problem
- ❑ Convulsions
- ❑ Developmental Problem
- ❑ Psychiatric Problem
- ❑ Other: ______________________

Please explain: ____

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3. Is your child on any medication? ❑ Yes ❑ No If yes, name of medication: ______________________

Reason for medication: ______________________ Prescribing Doctor: ______________________

Will he/she need to take it during the school day? ❑ Yes ❑ No At what time? ______________________

4. Has your child been hospitalized for any reason since birth? ❑ Yes ❑ No If yes, please explain: ______________

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5. Has you child had any major injuries? ❑ Yes ❑ No If yes, please explain: ______________________

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6. Does your child have any physical limitations ❑ Yes ❑ No Will he/she need any special considerations in school ❑ Yes ❑ No

Please explain: ____

7. Are there any problems at home which might affect your child's learning? ❑ Yes ❑ No

Please explain: ____

PLEASE CHECK YOUR CHOICE OF DOCTOR OR DENTISTS BELOW:

(GRADES K-6-9) I would like my family doctor ❑ or school doctor ❑ to examine my child

(GRADES K-3-7) I would like my family dentist ❑ or school dentist ❑ to examine my child

Parent or Guardian Signature: ______________________________________ Date: ______________

MED HISTORY (rev. 10/14)