THE SCHOOL DISTRICT OF PHILADELPHIA

PUPIL MEDICAL HISTORY

NAME OF SCHOOL	CLUSTER	DATE
NAME OF STUDENT	RM/BK/SEC	GRADE

DEAR PARENT/GUARDIAN:

PENNSYLVANIA LAW REQUIRES THAT ALL CHILDREN MUST HAVE A COMPLETE CHECK-UP WHEN ENTERING SCHOOL FOR THE FIRST TIME AND AGAIN IN MIDDLE AND HIGH SCHOOL.

YOUR FAMILY DOCTOR IS THE BEST PERSON TO DO THIS CHECK-UP AND PROVIDE ALL NECESSARY HEALTH CARE. IF YOU WOULD LIKE SOME HELP FINDING A FAMILY DOCTOR OR CLINIC, OR IF YOU HAVE OTHER CONCERNS ABOUT YOUR CHILD'S HEALTH, PLEASE CALL THE SCHOOL NURSE AT_____.

THE SCHOOL NURSE CAN ALSO HELP YOU WITH INFORMATION REGARDING HEALTH INSURANCE. THERE ARE FREE AND LOW COST INSURANCE PLANS FOR WHICH YOUR FAMILY MAY QUALIFY. THERE IS NO REASON FOR ANY CHILD IN PHILADELPHIA TO BE WITHOUT HEALTH CARE.

YOUR COOPERATION IS VERY IMPORTANT TO US. PLEASE TAKE THE ATTACHED FORM TO YOUR DOCTOR OR CLINIC WHEN YOU TAKE YOUR CHILD FOR THIS CHECK-UP AND RETURN THE COMPLETED FORM TO THE SCHOOL NURSE BY _____.

SINCERELY,

PRINCIPAL:	SCHOOL NURSE:

STUDENT'S MEDICAL HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

1. DO YOU HAVE HEALTH INSURANCE ? ☐ YES ☐ NO

   WHAT IS THE NAME OF YOUR HEALTH INSURANCE ? _____

2. WHERE DO YOU TAKE YOUR CHILD FOR CHECK UPS ? _____

3. DATE OF CHILD'S LAST PHYSICAL EXAMINATIONS ? _____

4. WHERE DO YOU TAKE YOUR CHILD IN AN EMERGENCY ? _____

5. WHERE DO YOU TAKE YOUR CHILD FOR DENTAL CARE ? _____

6. DATE OF CHILD'S LAST DENTAL EXAMINATIONS ? _____

7. WHAT MEDICINE IS YOUR CHILD NOW TAKING ? _____ HOW OFTEN _____ WHAT IS IT FOR _____

8. IS YOUR CHILD ALLERGIC TO ANY MEDICINE? ☐ YES ☐ NO IF YES, WHAT MEDICINE _____

9. NUMBER OF PERSONS LIVING IN SAME HOME AS YOUR CHILD? _____ ADULTS _____ CHILDREN

10. DO YOU WISH TO DISCUSS ANYTHING ABOUT YOUR CHILD'S HEALTH WITH THE SCHOOL / NURSE ? ☐ YES ☐ NO

(USE OTHER SIDE FOR COMMENTS)

CHECK ANY PROBLEM YOUR CHILD OR IMMEDIATE FAMILY MEMBER HAS HAD:

	FAMILY	CHILD
ALCOHOL/DRUG	☐	☐
ALLERGY/ASTHMA	☐	☐
ANEMIA	☐	☐
ARTHRITIS	☐	☐
BEHAVIOR/EMOTIONAL	☐	☐
CANCER	☐	☐
DENTAL	☐	☐
DIABETES	☐	☐

	FAMILY	CHILD
ECZEMA	☐	☐
FREQUENT COLDS	☐	☐
HEARING DIFFICULTY	☐	☐
HEART	☐	☐
HIGH BLOOD PRESSURE	☐	☐
HOSPITALIZED (OPERATIONS)	☐	☐
	☐	☐
	☐	☐

	FAMILY	CHILD
LEARNING PROBLEM	☐	☐
LUNG DISEASE	☐	☐
LEAD POISONING	☐	☐
MENTAL RETARDATION	☐	☐
MULTIPLE HANDICAP	☐	☐
MUSCLE/BONE/JOINT	☐	☐
NERVOUS TROUBLE	☐	☐
OVERWEIGHT	☐	☐

	FAMILY	CHILD
PHYSICAL HANDICAP	☐	☐
PREMATURE BIRTH (UNDER 5 LBS.)	☐	☐
SEIZURES	☐	☐
SPEECH DIFFICULTY	☐	☐
TUBERCULOSIS	☐	☐
VISION PROBLEMS	☐	☐
URINATION/KIDNEY	☐	☐
PROBLEM	☐	☐

CONTAGIOUS DISEASES YOUR CHILD HAS HAD:

	(AGE)
☐ CHICKEN POX	_____
☐ DIPTHERIA	_____
☐ GERMAN MEASLES	_____
☐ MEASLES	_____

	(AGE)
☐ MENINGITIS	_____
☐ MUMPS	_____
☐ PNEUMONIA	_____
☐ POLIOMYELITIS	_____

	(AGE)
☐ RHEUMATIC FEVER	_____
☐ SCARLET FEVER/STREP THROAT	_____
☐ TYPHOID FEVER	_____
☐ WHOOPING COUGH	_____

AGE TALKED _____ AGE WALKED _____ AGE TOILET TRAINED _____

TIRES EASILY ☐ BED WETTING ☐ NIGHTMARES ☐ CONSTIPATION ☐ INADEQUATE SLEEP ☐ POOR APPETITE ☐

WHEN WAS THE LAST TIME YOUR CHILD HAD A TUBERCULIN TEST? _____ RESULTS _____

IS YOUR CHILD IN GOOD HEALTH? ☐ YES ☐ NO