DERRY AREA SCHOOL DISTRICT

HEALTH AND DEVELOPMENTAL HISTORY

CHILDS NAME GRADE \_\_\_\_\_\_\_\_\_\_MALE FEMALE

ADDRESS PHONE

DATE OF BIRTH PLACE (Month/Day/Year) (Town) (State)

FATHERS NAME BIRTHPLACE

MOTHERS MAIDEN NAME BIRTHPLACE

**PLEASE make the school aware of any custody orders.**

Has your child had any of the following? Give details.

Yes No Yes No

⬜ ⬜ Allergy ⬜ ⬜ Seizure Disorder

⬜ ⬜ Operation (Note type) ⬜ ⬜ Emotional Problems

⬜ ⬜ Chicken Pox: Month Year ⬜ ⬜ Orthopedic Problems

⬜ ⬜ Diabetes ⬜ ⬜ Serious Accidents

⬜ ⬜ Asthma ⬜ ⬜ Chronic Ear Infections

⬜ ⬜ Heart Problems ⬜ ⬜ Tubes in Ears

⬜ ⬜ Attention Deficit Disorder ⬜ ⬜ Birth Defects

⬜ ⬜ Frequent Nosebleeds ⬜ ⬜ Head Injury

⬜ ⬜ Bowel Problems ⬜ ⬜ Eye Problems

⬜ ⬜ Poor Appetite ⬜ ⬜ Frequent Stomachaches

⬜ ⬜ Speech Problems ⬜ ⬜ Heart Disease/Murmur

⬜ ⬜ Kidney Disease ⬜ ⬜ Rheumatic Fever

⬜ ⬜ Hepatitis ⬜ ⬜ Measles (3 day)

⬜ ⬜ Mumps ⬜ ⬜ Measles (9 day)

⬜ ⬜ Whooping Cough ⬜ ⬜ Scarlet Fever

⬜ ⬜ Is your child taking any medications on a regular basis? If yes, list name(s) of Drugs(s) and how often below:

**IMMUNIZATIONS**

Prior to the time of admission to school, the State mandates that ALL children within the Commonwealth shall have received the required immunizations.

Medical records of these immunizations must be provided. If evidence is not available, the child will be denied entrance to school or a statement of exemption must be provided by parent/physician.

⬜ **Medical Exemption** – The physical condition of the above named child is such that immunization would endanger life or health.

⬜ **Religious Exemption** – Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian.

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

Name of Child’s Physician or other source of medical care:

Do you want your child taken to Excela Health Hospital Emergency Room if parent or physician cannot be contacted? ⬜ Yes ⬜ No

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| --- | --- | --- | --- |
| **WHICH OF THE FOLLOWING HAVE YOU OBSERVED IN YOUR CHILD? PLEASE CHECK.** | | | |
|  | Plays well with other children |  | Has fears or worries |
|  | Shares with others |  | Cries easily |
|  | Seeks friends |  | Thumb sucking |
|  | Follows instructions |  | Nail biting |
|  | Stumbles or drops things often |  | Bed wetting |
|  | Angers easily |  | Overactive |
|  | Discourages easily |  | Is withdrawn |
|  | Is distrustful |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **FAMILY MEMBERS** | | | |
| **Name** | **Birthdate** | **Relationship** | **Occupation OR Grade** |
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**PHYSICAL EXAMS ARE GIVEN IN KINDERGARTEN, 6TH AND 11TH GRADES.** You are encouraged to have the school health exam performed by your family physician and you will be provided with the proper form. **Otherwise, your child will be examined by the school physician.**

**DENTAL EXAMS ARE GIVEN IN KINDERGARTEN, 3RD AND 7TH GRADES.** You are encouraged to have the dental exam done by your family dentist and you will be provided with the proper form. **Otherwise, your child will be examined by the school dentist.**

**NOTE: MEDICAL/DENTAL FORMS ARE TO BE RETURNED TO THE SCHOOL NURSE AS SOON AS THEY ARE COMPLETED.**

If your child just entered our school, give name and address of school from which he/she came:

Please list any other information that the school nurse should be aware of:

SIGNATURE OF PARENT/GUARDIAN DATE