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 New Freedom, PA 17349
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Medical Health History

Student Information

Student's Name _____
Last First Middle

Home Phone _____ Gender Male Female Grade _____

Home Address _____

Date of Birth _____ Place of Birth (*City & State*) _____

Student's Physician _____ Physician's Phone _____

Physician's Address _____

Student's Dentist _____ Dentist's Phone _____

Dentist's Address _____

Family Information

Father _____ Mother _____

Brothers & Sisters in Household (*please list names and birthdays*):

Medical Information

Please check if your child has had any of the following. Please include date, if possible.

- | | | |
|------------------|----------------------------------|--------------------|
| ___ Mumps | ___ German Measles/3 Day measles | ___ 10 day measles |
| ___ Polio | ___ Whooping Cough | ___ Scarlet Fever |
| ___ Strep Throat | ___ Rheumatic Fever | ___ Meningitis |
| ___ Pneumonia | ___ Rubella | ___ Ear Infections |
| ___ Chicken Pox | ___ Other _____ | |

Immuzations & Dates

Boosters & Dates

	Immuzations & Dates	Boosters & Dates
Diphtheria & Tetanus	1st _____ 2nd _____ 3rd _____ 4th _____	1st _____ 2nd _____
Polio	1st _____ 2nd _____ 3rd _____ 4th _____	1st _____ 2nd _____
Measles, Mumps, Rubella	1st _____ 2nd _____	
Hepatitis B	1st _____ 2nd _____ 3rd _____	
HIB	1st _____ 2nd _____ 3rd _____	
Varicella (Chicken Pox)	1st _____ 2nd _____ or date of Varicella disease _____	
Other _____	1st _____ 2nd _____ 3rd _____ 4th _____	1st _____ 2nd _____
Tuberculosis Test	Date _____ Result _____ Positive _____ Negative _____	

Medical Information (con't)

Has your child had any operations, serious illnesses, or ever been hospitalized? Yes No

If yes, please explain _____

Is your child under any medical treatment at this time? Yes No

If yes, please explain _____

Is your child taking any medications at this time (please submit a *Request for Medication Administration Form*)? Yes No

If yes, please explain _____

Does your child need any emergency medication while in school (please submit a *Request for Medication Administration Form*)? Yes No

If yes, please explain _____

What was your child's weight at birth? _____ lbs _____ ozs

Were there any defects at birth? Yes No

If yes, please explain _____

Please use the space provided to list any other medical concerns that the school should know about your child.

Father's/Guardian's Signature _____

Date _____

Mother's/Guardian's Signature _____

Date _____