THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

CONFIDENTIAL MEDICAL HISTORY

DATE
CHOOL

Dear Parent / Guardian:

It will be helpful to have the following information so that the school can meet any health needs that your child might have.

LAST NAME (PUPIL)	FIRST NAME	MIDDLE NAME	DATE OF BIRTH

PARENTS OR GUARDIANS

MOTHER'S NAME		FATHER'S NAME	
HOME ADDRESS		HOME ADDRESS	
HOME PHONE	WORK PHONE	HOME PHONE	WORK PHONE
WORKPLACE		WORKPLACE	

Person looking after child during day / after school

NAME	ADDRESS	PHONE

Relative / friend to contact in emergency when above people cannot be contacted:

NAME	ADDRESS	PHONE

Doctor to be notified:

NAME	ADDRESS	PHONE
In an emergency, if a choice is possible, which hospital would you prefer for your child?		

I give permission to the staff of the School District of Philadelphia to transport, or to make arrangements for the transportation of, my child to emergency medical care, in the event that the persons listed above cannot be contacted. I understand that if necessary, my child will receive medical treatment.

NAME of PARENT/GUARDIAN (Print)	DATE SIGNED	SIGNATURE OF PARENT/GUARDIAN X

1. Is the child under care of a physician, hospital or clinic now? ☐ NO ☐ YES
   Where? _____ What for _____
   a._____
   b._____
2. Is your child taking any medicines, tablets, or vitamins? ☐ NO ☐ YES
   What? _____ What for _____
3. Does your child need to take any medicines, tablets, or vitamins at school? ☐ NO ☐ YES
   What? _____ What for _____
4. Is your child allergic to anything, such as foods, plants, insects, medicines, other? ☐ NO ☐ YES
   What? _____
5. Has your child had any convulsions or seizures in the past year? ☐ NO ☐ YES
   How many? _____Treatment_____
6. Does your child need a special diet or have any food problems? ☐ NO ☐ YES
   Give details _____
7. Does your child have any *special* health needs or problems the school should know? ☐ NO ☐ YES
   What? _____
8. Where is the child usually taken when he is sick? Give the names of doctors or hospitals
   _____
9. Has the child ever been seen by a dentist? ☐ NO ☐ YES
   Name of dentist _____
10. Does the family have some way to help pay for medical expenses? ☐ NO ☐ YES
    What: Blue Cross, Union, D.P.A. (white card), Medical Assistance (blue card), Medicare, Other _____

PUPIL'S HEALTH HISTORY

1. **Family Health History**

a. Circle any of the following diseases that this child's blood relatives, living or dead (e.g., parents, grandparents, aunts, uncles, brothers, sisters) have had:

allergy	drug or alcohol	heart disease	seizures	mental retardation	other inherited or
asthma	addiction	high blood pressure	tuberculosis (T.B.)	sickle cell disease	family diseases
cancer	diabetes	nervous breakdown	lead poisoning	sickle cell trait	

b. Family / Household Members
(Note any special relationships such as step-parent, adopted, foster-child, grandparents, etc.)

RELATIONSHIP	AGE	NAME	STATE OF HEALTH	OCCUPATION OR SCHOOL	GRADE REACHED IN SCHOOL
Mother					
Father					
Brothers					
Sisters					
Other House Hold Members					

c. Have any members of the family died? (not miscarriages) _____

d. How many members of the family live in the same house as the child?_____

e. Are there any family problems such as problems with housing, employment, food, etc.? ☐ NO ☐ YES

2. **Pregnancy and Birth**

a. Did the mother have any illness during the pregnancy? ☐ No ☐ Yes

b. Did the mother take any medicines (other than iron or vitamins) during the pregnancy? ☐ No ☐ Yes

c. Was the mother or the family under any unusual strain during the pregnancy? ☐ No ☐ Yes

d. Did the baby come on time? ☐ No ☐ Yes

e. Was it a difficult birth? ☐ No ☐ Yes

f. Were instruments used? ☐ No ☐ Yes

g. What was the baby's birth weight? _____

h. Did the baby have any trouble while in hospital? ☐ No ☐ Yes

i. How many days did the baby stay in the hospital? _____

j. How many days did the mother stay in the hospital? _____

3. **Early Childhood History**

a. Would you describe the baby as average quiet or active? _____

b. Did the baby have any special problems in the first six months? ☐ No ☐ Yes

c. Was the baby breast fed? ☐ No ☐ Yes

d. How old was the baby when breast feeding was stopped? _____

e. How old was the child when bottle-feeding was stopped? _____

f. At what age did the child sit alone withou support? _____

g. At what age did the child crawl? _____

h. At what age did the child walk alone without support? _____

i. At what age did the child begin to say two or three words together? _____

j. Can the child use the toilet without help now? ☐ No ☐ Yes

k. At what age did the child stop wetting the bed? _____

4. Child Health History

1. Has the child ever been in a hospital or had an operation? ☐ No ☐ Yes

	WHEN	REASON	NAME OF HOSPITAL
a.			
b.			

2. Has the child had any other illnesses, accidents, broken or fractured bones, head injuries? ☐ No ☐ Yes

	WHEN	WHAT WAS THE PROBLEM?	HOW LONG DID IT LAST?
a.			
b.			

3. Would you say the child's health could be better? ☐ No ☐ Yes

4. Check (V) any of the following illnesses the child has had:
   ☐ "red" measles ☐ pneumonia ☐ chicken pox
   ☐ whooping cough ☐ mumps
   ☐ German or "3" day measles ☐ rheumatic fever

5. Has the child ever been knocked completely unconscious? ☐ No ☐ Yes

6. Has the child had more than six colds or throat infections, with a fever, a year? ☐ No ☐ Yes

7. Is the child often confined to bed by illness? ☐ No ☐ Yes

8. Has the child had any trouble with ear or hearing? ☐ No ☐ Yes

9. Has the child had any trouble with eyes or seeing? ☐ No ☐ Yes

10. Does the child seem to have trouble breathing through the nose? ☐ No ☐ Yes

11. Does the child snore at night? ☐ No ☐ Yes

12. Does your child have frequent nosebleeds? ☐ No ☐ Yes

13. Has the child had any trouble with teeth? ☐ No ☐ Yes

14. Does the child's breath have a bad odor? ☐ No ☐ Yes

15. Has the child ever had a convulsion? ☐ No ☐ Yes

16. Does the child have periods when you talk to him and s/he doesn't seem to hear you? ☐ No ☐ Yes

17. Hasthe childever had a fainting spell? ☐ No ☐ Yes

18. Does the child complain of headaches? ☐ No ☐ Yes

19. Has a doctor ever said the child had a heart murmur? ☐ No ☐ Yes

20. Has the child ever complained of pain in the arms or legs? ☐ No ☐ Yes

21. Has the child ever had swell ing of any joints or limping? ☐ No ☐ Yes

22. Does the child have trouble keeping up with other children? ☐ No ☐ Yes

23. Do any foods disagree with the child? ☐ No ☐ Yes

24. Does the child often have diarrhea? ☐ No ☐ Yes

25. Has constipation ever been much of a problem for this child? ☐ No ☐ Yes

26. Has the child ever had worms or parasites? ☐ No ☐ Yes

27. Have you ever seen blood in the child's stools (bowel movements)? ☐ No ☐ Yes

28. Has the child ever had yellow jaundice or trouble with the liver? ☐ No ☐ Yes

29. Does the child complain of belly aches? ☐ No ☐ Yes

30. Does the child have any problem with passing water (urination)? ☐ No ☐ Yes

31. Has the child ever been treated for kidney problems? ☐ No ☐ Yes

32. Has the child (girls only) started having menstrual periods? ☐ No ☐ Yes

32a. Does she have any problems? ☐ No ☐ Yes

33. Does the child have any skin problems, eczema? ☐ No ☐ Yes

34. Has the child ever had asthma, wheezing or coughing? ☐ No ☐ Yes

35. Does the child have any deformity of bones or joints? ☐ No ☐ Yes

36. Has there ever been any trouble with the child's blood? ☐ No ☐ Yes

37. Has the child ever eaten paint or plaster or anything else which is not food? ☐ No ☐ Yes

38. Does the child have any trouble sleeping or falling asleep? ☐ No ☐ Yes

39. How does the child put himself or herself to sleep?
   _____
   _____
   _____

40. Has the child ever had a skin test for T.B. (tuberculosis)? ☐ No ☐ Yes
   Was the test normal? ☐ No ☐ Yes
   Date of last test _____

41. Do you think the child is overweight? ☐ No ☐ Yes

42. Do you think the child is underweight ☐ No ☐ Yes

43. What does the child usually eat for:

BREAKFAST	SUPPER
LUNCH	SNACKS

How many glasses of milk a day?

5. Put a circle around any of the following things which worry you about the child:

1. Bedwetting
2. Wetting during the day
3. Thumbsucking
4. Nail biting
5. High tense or easily upset?
6. Too restless
7. Shy
8. Sad or sulky
9. Unhappy or depressed
10. Feelings easily hurt
11. Wanting too much attention
12. Wanting too much comfort or support from parent
13. Day dreams
14. Nightmares
15. Temper tantrums
16. Contrary or stubborn
17. Disobedient
18. Lying
19. Selfish in sharing
20. Gets along poorly with family
21. Jealous of brothers and sisters
22. Stays out too late
23. Fighting with other children
24. Keeps bad company
25. Purposely destroys things
26. Gets along poorly at school
27. Feeding
28. Bad eating habits
29. Bowels
30. Any other problems not mentioned? What?

6. Current Functioning of the Child

a. How would you describe the child as a person?_____ _____
_____

b. How does the child get along with brothers and sisters? _____
_____

c. How does the child get along with neighborhood friends? _____
_____

d. How does the child feel about coming to school? _____
_____

e. How is the child doing with his school work? _____
_____

f. What does the child like to do? _____
_____

g. What kinds of things scare or worry the child? _____
_____

h. What are some of the things the child does that upset you or make you angry? _____
_____

i. What do you do to discipline the child? How does he or she react? _____
_____

j. What are some of the things the child does which please you or make you proud? _____
_____

k. Do you have any concerns which you would like to discuss with a nurse or physician? _____
_____

Completed by	Date	Received by	Date