

UPPER MORELAND SCHOOL DISTRICT
HEALTH HISTORY

The information requested on this form will be of help to the school authorities in determining the health status of your child and in assisting him/her to receive maximum benefits from his/her educational opportunity.

Student's Full Name _____ Birth Date _____

Father's Name _____ Mother's Name _____ Home Phone _____

Address _____

Student's Physician or other source of medical care _____ Dr.'s Phone No. _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? GIVE DETAILS

Allergy: Drug _____ Food _____ Animal _____ Other _____

Recurring Illness: _____

Surgery: _____ Date _____

Serious Accident: _____ Date _____

Hearing Problem: _____ Treatment: _____ Under Care: Yes ___ No ___

Vision Problem: _____ Under Care: Yes ___ No ___

Treatment: Glasses _____ Patch _____ Other _____

Heart Murmur: _____ Treatment: _____ Under Care: Yes ___ No ___

Emotional Problem: _____ Treatment: _____ Under Care: Yes ___ No ___

Speech Problem: _____ Under Care: Yes ___ No ___

Other Conditions: _____ Long Term/Daily Medication: _____

I certify that the above information is correct and I understand that relevant information regarding my child's health may be shared with appropriate school personnel for the safety of my child.

SIGNATURE OF PARENT OR GUARDIAN: _____ Date: _____