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.**

ALL IMMUNIZATIONS AND BOOSTER DATES MUST INCLUDE MONTH, DAY, YEAR

	1st	2nd	3rd	4th	Booster
DPT/DT-one after 4th birthday					
Polio					
Hepatitis B					
MMR-two after 1st birthday					
Varicella (Chicken Pox)					
HIB-Not state required					
TB Test-High risk only					

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: _____