TAMAQUA AREA ELEMENTARY SCHOOLS
SCHOOL HEALTH SERVICE
HEALTH HISTORY

The information requested on this form will be helpful to determine the health status of your child and assist her/him to receive maximum benefits from her/his educational experience.

NAME: _____ SEX: ____ BIRTHDATE: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____ TELEPHONE NUMBERS: _____/_____
(STREET/PO BOX) (CITY) (STATE) (ZIP CODE) (HOME) (CELL)

FATHER'S NAME: _____

MOTHER'S NAME (INCLUDE MAIDEN NAME): _____

HEALTH HISTORY

BIRTH WEIGHT: ____LB. ___OZ. BORN PREMATURELY: YES OR NO

Has your child ever had any of the following?

	YES	NO	DATE		YES	NO	DATE
Chicken Pox	___	___	_____	Convulsive Disorders	___	___	_____
Measles	___	___	_____	Allergies	___	___	_____
Mumps	___	___	_____	What kind?	_____		
German Measles	___	___	_____	Asthma	___	___	_____
Pneumonia	___	___	_____	Allergic to Bee Sting	___	___	_____
Scarlet Fever	___	___	_____	Ear Conditions	___	___	_____
Rheumatic Fever	___	___	_____	Vision Problems	___	___	_____
Blood Disorders	___	___	_____	Accidents/Surgeries:	_____		
Diagnosis:	_____						
Heart Disease	___	___	_____	Illnesses/Health Concerns	_____		
Diagnosis:	_____						

Is your child taking any medications: Yes or No Please List: _____

MEDICAL INSURANCE NAME: _____

FAMILY PHYSICIAN: _____ FAMILY DENTIST: _____

******PLEASE PROVIDE A COPY OF IMMUNIZATION RECORDS WITH THIS FORM******

SIGNATURE: _____ DATE: _____

**********(TO BE COMPLETED BY THE NURSE)**********

SCREENING DATE _____

VISION

NEAR
RIGHT _____
LEFT _____

FAR
RIGHT _____
LEFT _____

COMMENTS:

AUDIOMETRIC
(SWEEPCHECK OF 25 db EACH EAR)

RIGHT EAR _____
LEFT EAR _____

COMMENTS:

Revised: 1/8 SB:ps

TAMAQUA AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
Notice of Health Examinations

In compliance with the School Health Laws of Pennsylvania, periodic medical examinations are required for all children who are or should be attending school. These examinations are made in grades **kindergarten, six, and eleven.** You are encouraged to have the examination performed by your family physician, at your expense, for which a proper form will be given to you if indicated.

If you desire the examination by the school doctor, it will be done in the building, which your child attends, at no cost to you. Our school examinations are age appropriate and are guided by the recommendations of the State and the Guidelines of the American Academy of Pediatrics. These examinations are not intended to be comprehensive or to treat acute illnesses; instead they are intended to screen for developmental abnormalities such as scoliosis, or other potential chronic medical conditions, which require medical attention. These examinations are conducted on school premises in the respective nurse's office and are supervised by a school nurse. Each child receives an examination of the head, ears, eyes, nose and throat, heart and lungs are ausculted, and the abdomen is palpated as part of the general medical examination. According to grade level, a scoliosis screening is performed and in male patients an examination of the genitalia is performed to screen for undescended testicles or hernias.

Please complete the following information, indicate your preference and return to the school nurse.

_____ _____ _____
Name of Child Birthdate Grade

_____ _____
Name of Parent or Guardian Name of Family Physician

List ONLY the following that have occurred since the last school examination:

Illness (Physical or Emotional) _____

_____

Severe Injuries _____ Date: _____

Surgery _____ Date: _____

Allergies _____

Medications _____

** Please check ONE: I wish the medical examination to be done by:

_____ **FAMILY Doctor** _____ **SCHOOL Doctor**

_____ _____
Signature of Parent or Guardian Date

TAMAQUA AREA ELEMENTARY SCHOOLS
SCHOOL HEALTH SERVICE – NOTICE OF DENTAL EXAMINATION

NAME: _____ GRADE: _____

TEACHER: _____ BUILDING: _____

Dear Parent/Guardian:

On compliance with the School Dental Health Laws of Pennsylvania, periodic dental examinations are required for all children who are attending school, in grades 1, 3, 7.

You are encouraged to have the examination done by your family dentist since he/she can best evaluate your child's d3ental health and assist you in obtaining necessary treatments and corrections. The appropriate form will be forwarded to you if you give permission for your family dentist to examine your child's teeth.

However, if no family dentist is available, the school dental examination (at no cost to you) will be given to your child in the building in which he/she attends during this school year. **Please note below any special condition you wish to call to the attention of the school dentist.**

Please complete the form and return to your child's teacher by _____
Thank you.

***** PLEASE CHECK ONE:

I wish the dental examination to be done by:

_____ **Family dentist** _____ **School Dentist**

COMMENTS:

_____
Signature of Parent/Guardian

_____
Date