Tredyffrin/Easttown School District
Student Health History

Name of Child_____ Birthdate _____ Grade _____

Name of Child's Physician _____ Telephone # _____
Date of last physical examination: _____

Name of Child's Dentist_____ Telephone # _____
Date of last dental examination: _____

Is your child allergic to any drug, insect bite, food, or other substance? Are any allergies life-threatening? Does he/she carry an epinephrine auto injector?

_____

Does your child have any condition requiring special attention such as a cardiac problem, asthma, diabetes, epilepsy or other? If yes, please list.

_____

Does your child have any problem with coordination or mobility? If yes, please list.

_____

Does your child have any problem with vision, hearing, speech, or communication? If yes, please list and explain.

_____

Does your child have any socialization or emotional problems? If yes, please list.

_____

Has your child had any serious accident, illness, or operation? If yes, please describe.

_____

Does your child take any medication? If yes, please list medication and dosage.

_____

_____

Has your child had any of the following illnesses? If yes, check illnesses that apply.

Chicken Pox _____ Mumps _____ Whooping Cough _____
German Measles ____ Measles _____ Polio _____

May the School Nurse share this information with other school staff? Yes ___ No ____

Signature of Parent or Guardian _____ Date _____