**CHARLEROI AREA**  **SCHOOL DISTRICT**

**125 Fecsen Drive Charleroi, PA 15022-2299**

**Elementary School Nurse: Heather Fox-Sutek RN, BSN, CSN**

**724-483-5554 ext.2264 Fax: 724-489-9367**

**Middle School/High School Nurse: Dana Cannon**

**724-483-3509 ext. 3022 Fax: 724-489-9128**

# HEALTH HISTORY

The following information will assist the school nurse in the planning and care of your child. Any information you provide is confidential and will not be disclosed without your consent.

NAME OF CHILD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_

## CHILD’S DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CHILD’S GENDER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FATHER’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### GUARDIAN’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATION TO CHILD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any medical conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child experienced difficulty with or had any of the following? (circle yes or no) If yes, please explain below.

|  |  |  |  |
| --- | --- | --- | --- |
| Asthma  Chicken Pox  Allergies (list allergy below)  Eyes/Vision  Diabetes  Ears/Hearing  Seizures  Mouth/Dental  Emotional/Behavioral  Stomach/Bowels  Premature Birth | Y N  Y N  Y N  Y N  Y N  Y N  Y N  Y N  Y N  Y N  Y N | Kidney/Bladder  Serious Injury/Illness  Bone/Muscle  Arthritis  Heart/Lungs  Frequent Headaches  Skin  Surgery  Developmental Delay  Cystic Fibrosis  Other | Y N  Y N  Y N  Y N  Y N  Y N  Y N  Y N  Y N  Y N  Y N |

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Is your child currently on medication? Please list all prescriptions, over the counter medications, and supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If your child will require medication during school hours, the district medication administration form will need filled out by your child’s doctor. This form is required for both prescription and over the counter medications and is located on our website.)*

Is there any other information you feel would be helpful in caring for your child?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_