SHIPPENSBURG AREA SCHOOL DISTRICT

Name: _____ Date of Birth _____ Grade _____

Student Health History

Health Conditions (Please check any that apply and provide details on the back of this form)

☐	Asthma	☐	Heart problems
☐	Attention Deficit Disorder	☐	Bleeding disorders
☐	Birth or congenital malformation	☐	Kidney/Bladder problems
☐	Bone or joint deformities	☐	Tourettes / Nervous Tics
☐	Cerebral palsy	☐	Peanut/Nut allergy
☐	Cystic Fibrosis	☐	Bee sting allergy
☐	Diabetes	☐	Medication allergy : _____
☐	Behavioral/Mental Health Issues	☐	Food allergy : _____
☐	Epilepsy/Seizure Disorder	☐	Other allergy: _____
☐	Headaches/migraines	☐	Other:
☐	Hearing problems	☐	Other:

If you checked any allergy, please describe the symptoms your child has had with the allergic reaction and Emergency measures we need to take: _____

_____

Current Medications: _____

_____

Other Health information (hospitalizations, surgeries, etc.) _____

_____

Any changes in your family status or other situations that may affect your child? _____

_____

List Brothers and Sisters names, age and grade: _____

_____

My child may be given Acetaminophen (generic Tylenol), Antacid (tums) or cough drops at school per Shippensburg Area School District policies and procedures. _____Yes _____ NO

My child may receive assistance from school staff for intimate care or toileting concerns. _____ Yes _____No

Parent Signature _____ Date _____