The School District *of* Haverford Township

SCHOOL HEALTH RECORD

(*to be completed by parent or guardian*)

Student's name:	Date of birth:
Address:	Telephone No.
	School:
Parent/guardian's name:	Parent/Guardian's name:

CHILDHOOD ILLNESSES

Check all illnesses your child has had

- ❑ Chicken Pox
- ❑ Whooping Cough
- ❑ Scarlet Fever
- ❑ Rheumatic Fever
- ❑ German Measles
- ❑ Measles
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Pneumonia
- ❑ Mumps
- ❑ _____
- ❑ _____

Operations: _____

Allergies: _____

Ear infections: _____

Bee sting reaction (*circle one*) **MILD** **SEVERE** **NONE** **UNKNOWN**

Is your child presently under medical treatment? (*circle one*) **YES** **NO**

My child may have Tylenol: (*circle one*) **YES** **NO**

I give my permission for my child's medical information to be shared with the faculty and/or staff members who need to know in order to provide for my child's health and safety. (*circle one*)

YES **NO**

List any illnesses or health problems which you or your family physician feel should be made known to school authorities: _____

_____

_____

_____

Signature of Parent or Guardian

_____

Date

DISTRIBUTION: School Nurse