Chestnut Ridge School District
3281 Valley Rd
Fishertown PA 15539
Phone 8124-839-4195

Health History

Name of Child: _____Date of Birth: _____
(Last) (First) (Middle)

Father's Name: _____
(Last) (First) (Middle)

Mother's Name: _____
(Last) (First) (*Maiden)

Person(s) with whom student lives if other than parent: _____

Child's Physician _____

Child's Dentist _____

1. Has your child ever been hospitalized or had surgery? _____ Yes _____ No
   Date Reason Name of Hospital
   _____
   _____
   _____
2. Has your child had any other serious illnesses, accidents, broken or fractured bones?
   _____ Yes _____No Date _____ Problem _____
   _____
   _____
   _____
3. Is your child allergic to anything? _____Yes _____No
   If yes, please list: _____
4. Is your child presently under medical treatment? _____ Yes _____ No
   If yes, please explain. (List medications and reason for taking it)
   _____
   _____
5. Do you suspect any difficulty with your child's hearing? _____ Yes _____ No
   Do you suspect any difficulty with your child's sight? _____Yes _____ No
   Do you suspect any difficulty with your child's speech? _____ Yes _____ No
6. List all other children in the family (at home or in school) and their date of birth.
   _____ _____ _____
   _____ _____ _____
7. Circle any of the following diseases that have occurred in your family. List the relationship to your child after each one (include grandparents, aunts, and uncles).
   allergies_____ diabetes _____lead poisoning _____
   asthma _____ heart disease _____mental illness_____
   cancer_____ seizures _____mental retardation_____
   drug addiction_____ TB_____
   sickle-cell_____ alcohol addiction_____
   other _____