LAKELAND SCHOOL DISTRICT
1355 Lakeland Drive
Scott Township, Pennsylvania 18433
Telephone: 570-254-9485
Fax: 570-254-6730

MEDICAL HISTORY REPORT

Student's Name: _____ Sex: ____ Grade: ____ Birthdate: _____

Address: _____

Contact Information (LIST IN ORDER OF CALL PRIORITY)

1st _____, _____ Phone (h): _____ (c) _____ (w) _____
(Name) (Relationship)

2nd _____, _____ Phone (h): _____ (c) _____ (w) _____
(Name) (Relationship)

3rd _____, _____ Phone (h): _____ (c) _____ (w) _____
(Name) (Relationship)

4th _____, _____ Phone (h): _____ (c) _____ (w) _____
(Name) (Relationship)

5th _____, _____ Phone (h): _____ (c) _____ (w) _____
(Name) (Relationship)

With whom does the student live? _____ Relationship: _____

1. Does your child have any health problems? (check all that are appropriate)

☐ Asthma*	☐ Lung Problem	☐ Seizures
☐ Allergies**	☐ Urinary Problem	☐ Developmental Problem
☐ Anemia	☐ Orthopedic Problem	☐ Psychiatric Problem
☐ ADHD	☐ Gastrointestinal Problem	☐ Other _____
☐ Diabetes	☐ Vision Problem	
☐ Heart Problem	☐ Hearing Problem	

* ☐ Due to the severity of my child's asthma, his/her inhaler must be kept with the nurse, or on his/her person.
** ☐ Due to the severity of my child's allergy, his/her epinephrine auto-injector must be kept with the nurse or on his/her person.
(Parents that check either box must follow proper procedures per the school handbook and/or Board Policy #210)

Please explain all other checked items: _____

_____

2. Is your child on any medication? ☐ Yes ☐ No If yes, name of medication(s): _____
_____ Reason for medication(s): _____
_____ Prescribing Doctor: _____
3. Does your child have any physical limitations? ☐ Yes ☐ No. Will he/she need any special considerations in school? ☐ Yes ☐ No. Please explain: _____
4. May your child be taken to the hospital if necessary? ☐ Yes ☐ No
If yes, name of hospital(s): _____

Parent/Guardian Signature: _____ Date: _____