THE SCHOOL DISTRICT OF PHILADELPHIA
STUDENT MEDICAL INFORMATION

This form is to be used for new students and capturing annual updates.

Last Name:	First Name	Date of Birth	Date:
Name of School:		Room/Section:	Grade:

Dear Parent/Guardian:

Pennsylvania law requires that all children must have a complete checkup when entering school for the first time and again in middle and high school.

The school nurse can help you with information regarding health insurance. There are free and low-cost insurance plans for which your family may qualify. Please take the attached form to your doctor or clinic when you take your child for this checkup and return the completed form to the school nurse by ________________

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature ____Date________________

STUDENT'S MEDICAL HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

1. Does your child have health insurance? __Yes __ No Company? ____________________________
2. Where do you take your child for checkups? ____

   Address: ____

   Phone: ___________________________________ Fax: __________________________________
3. Date of child's last physical examination? ____
4. Where do you take your child for dental care? ____

   Address: ____

   Phone: ___________________________________ Fax: __________________________________
5. Date of child's last dental examination? ________________

THE SCHOOL DISTRICT OF PHILADELPHIA
STUDENT MEDICAL INFORMATION

6. Does your child take any medicine now? __Yes __ No If yes, list below:

Medicine:	Dosage:	Frequency:	Reason:

7. Does your child have any allergies? __Yes __ No If yes, to what? ______________________________

8. Does your child have any activity restrictions? __Yes __ No If yes, explain? ____________________

9. Does your child have any existing Health Conditions? __Yes __ No If yes, list below:

_____________________________ _____________________________ _____________________________

10. Does your child receive treatment/therapy or undergo any testing procedures? __Yes __ No

If yes, please indicate kind and how often taken: ____

11. Check this box if you do not want Acetaminophen (Tylenol) dispensed to your child, as needed: ☐

12. Check this box if you do not want Ibuprofen (Motrin) dispensed to your child, as needed: ☐

Important Note: SDP may dispense Acetaminophen or Ibuprofen to your child if you do not opt-out.

PLEASE CHECK ANY PROBLEM YOUR CHILD HAS/HAS HAD

- ☐ Asthma
- ☐ Anemia
- ☐ Arthritis
- ☐ Behavior/Emotional
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Chicken Pox at age:___
- ☐ Dental
- ☐ Diabetes
- ☐ Drug/Alcohol
- ☐ Eczema
- ☐ Frequent Colds
- ☐ Hearing Difficulty
- ☐ Heart
- ☐ High Blood Pressure
- ☐ Hospitalized (Surgery)
- ☐ Learning Problem
- ☐ Lung Disease
- ☐ Lead Poisoning
- ☐ Meningitis
- ☐ Muscle/Bone/Joint
- ☐ Physical Disability
- ☐ Premature Birth (Under 5lbs)
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Tuberculosis
- ☐ Vision Problems
- ☐ Urinating/Kidney Problem

Additional Comments: ____
____
____
____