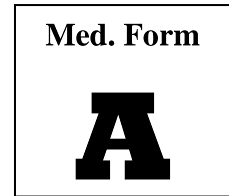
Jersey Shore Area School District

175 A&P Drive, Jersey Shore, PA 17740



Health History

Name ____ Date of Birth ___________________________

Please check all that apply

Does your child have:			Has your child had:			
Cleft Palate/Lip	Yes	No	Broken Bones	Yes	No	
Frequent Sore Throats	Yes	No	Tonsils Removed	Yes	No	
Frequent Earaches	Yes	No	Head Injury(unconscious)	Yes	No	
Frequent Colds	Yes	No	Difficult Sleeping	Yes	No	
Allergies	Yes	No	Convulsions	Yes	No	
Speech Difficulties	Yes	No	Epileptic Seizures	Yes	No	
Chronic Cough	Yes	No	Chicken Pox	Yes	No	If yes, month/year:___________
Emotional Problems	Yes	No	Measles (Regular/10 Day)	Yes	No	
Bedwetting/Wetting	Yes	No	Measles (German/3 Day)	Yes	No	
Frequent Nightmares	Yes	No	Mumps	Yes	No	
Poor Eating Habits	Yes	No	Scarlet Fever	Yes	No	
Stomach Problems	Yes	No	Whooping Cough	Yes	No	
Bowel Problems	Yes	No	Rheumatic Fever	Yes	No	
HIV/AIDS	Yes	No				
Behavioral Problems	Yes	No				
Vision Problems	Yes	No				

Explain all *Yes* answers:____

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____

Abnormal Birth History:____

List all operations:____

List all major illnesses:____

List all current daily medications, include dose:____

____

List all as needed medications, include dose:____

____

Is your child presently under medical treatment (if yes, explain):_________________________________

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____

Family History

(Please check those that apply to your family)

Allergies	Epilepsy	Tuberculosis	Heart Disease	Kidney Disease
Asthma	Deafness	Diabetes	Psychiatric Depression	

_______________________________________ _______________________________________

Parent/Guardian Signature Date

Rev. 12/11