

**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** \_\_\_\_\_

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**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? \_\_\_\_\_

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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**

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

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_