ARMSTRONG SCHOOL DISTRICT
181 Heritage Park Drive –Suite 2
Kittanning, PA 16201-7025

STUDENT HEALTH HISTORY

Please complete the following health history for your child. If you do not wish to answer a particular question, simply leave it blank.

Student's Name:_____ Sex: M_____F_____Birthdate:_____

Male Guardian's Name:_____Relationship:_____Year of Birth:_____

Female Guardian's Name:_____Relationship:__ _____Year of Birth:_____

Student lives with: Both Parents___Mother___Father___Legal Guardian___Foster Parents___Group Home___

Brothers:_____Birthdate:_____Sisters:_____Birthdate:_____

_____ _____ _____ _____

_____ _____ _____ _____

I. FAMILY HEALTH HISTORY

1. Circle and describe any condition the student's parents, grandparents, aunts, uncles, brothers or sisters have had: allergy, asthma, cancer, drug or alcohol addiction, diabetes, heart disease, depression, seizures, tuberculosis, sickle cell anemia, vision problem, hearing problem, learning problem, other inherited or family diseases (specify)

_____
_____

II. DEVELOPMENTAL HISTORY

1. Student's Birth Weight:_____Explain any problems or complications:_____
   _____
2. List approximate age when student: Sat without support_____Walked alone_____
   Spoke two or three words together_____Toilet trained_____
3. Menstrual History (Girls Only): Age of Onset_____Problems/Medication:_____
   _____

(OVER)

TO BE COMPLETED BY PARENT

A. Medical History: List date of onset for ones that apply to your child.

_____Attention Deficit/ADHD
_____Arthritis
_____Asthma triggers
  _____allergies
  _____exercise
  _____infection
  _____weather
_____Autoimmune Deficiency
_____Bladder Control
_____Bleeding Disorder/Anemia
_____Bowel Control
_____Chicken Pox
  _____vaccine
  _____disease
_____Cystic Fibrosis
_____Color Blindness
_____Connective Tissue Disorder
_____Dental Condition
_____Developmental Delay
_____Diabetes
_____Dietary Restrictions
_____Eatting Disorder
_____Fainting Spells
_____Gastrointestinal Condition
_____Headaches
_____Head Injury/Concussion
_____Hearing Deficit
_____Heart Condition
_____High Blood Pressure
_____Kidney Condition
_____Lung Condition
_____Malignancy
_____Neurological Disorder
_____Neuromuscular Disorder
_____Nosebleeds
_____Orthopedic Cond./Fractures
_____Psychiatric Cond./Emotional
_____Seizures
_____Skin Disorder
_____Speech Difficulty
_____TB Exposure
_____Thyroid Condition
_____Vision Deficit
  _____severe loss
  _____eye surgery
  _____glasses/contacts
_____Other (Specify)_____
_____
_____
Use this space, if needed, to elaborate on any above condition(s).
_____
_____
_____
_____
_____

B. Allergies: foods_____bees_____drugs_____plants/animals_____other_____
Please describe the allergic reaction and treatment: _____
_____
_____

C. Is medication needed for allergy:
At home? No_____Yes_____Name of Medication_____
At school? No_____Yes_____(If yes, please complete Form "Medication at School.")
Does the student take any medication regularly? No_____Yes_____(Please list medication(s) and dosage(s):
_____

D. List major operations, injuries, or hospitalizations. Give dates: _____
_____
_____

E. Last eye examination (date) _____ by Dr. _____
Last dental examination (date) _____ by Dr. _____
Last medical examination (date) _____ by Dr. _____

F. Is there anything you can tell us about your child that you feel will help the school staff to better understand and work with him/her?_____
_____
_____

I UNDERSTAND AND AGREE THAT ANY MEDICAL INFORMATION MAY BE SHARED WITH APROPRIATE SCHOOL AND MEDICAL PERSONNEL.

_____ _____ _____
Signature of Parent/Guardian **Relationship** **Date**

Revised 02/24/2010