Policy No. 209.1 AR- 3
PETERS TOWNSHIP
SCHOOL DISTRICT

ADMINISTRATIVE
REGULATION

Peters Township School District

Health History for School Nurse

TO HELP US GET TO KNOW YOUR CHILD BETTER AND PROVIDE NECESSARY CARE, PLEASE COMPLETE THE FOLLOWING:

Name: _____ Grade: _____ School Year: _____

☐ Asthma
Medication: _____

☐ Allergies:
Food: _____
Medication: _____
Bee/Insect: _____
Other: _____
Does your child have an Epi-Pen? ☐ Yes ☐ No

☐ Congenital Condition
Explain: _____

☐ Diabetes

☐ Fainting

☐ Headaches
☐ Diagnosis of Migraines

☐ Head Injury/Concussion

☐ Hearing Defect

☐ Heart Disease
Congenital Defect: _____
Murmur: _____
Activity Restriction? ☐ Yes ☐ No

☐Hospitalization:
Date/s: _____
Reason: _____

☐ Psychological Concern
☐ ADHD
☐ PDD
☐ODD
☐ Autism Spectrum
☐ Other: _____

1. Please list any daily medication/s: _____
2. Is the student presently under care of a physician for a medical or psychological condition?
_____
3. Does the student have any activity restrictions? _____

Parent Signature: _____ Date: _____

Revised 2-7-17