MANHEIM CHRISTIAN DAY SCHOOL

686 Lebanon Road
Manheim, Pennsylvania 17545

(717) 665-4300 FAX (717) 664-4253
www.manheimchristian.org

Health History

_____ _____ _____
Last Name First Middle Birthdate Gender (M/F)

_____
Street Address City State Zip

_____ _____ _____ _____
Father's Name Phone Mother's Name Phone

_____ _____
Parent/Guardian with whom child resides (if different from above) Phone

1. Does child have any allergies to medicine, food, bee stings, pollens, etc? Yes No
   If yes, please list: _____
   Please list action steps needed during an allergic reaction_____
   _____

2. Does child have any trouble with his/her eyes or seeing? Yes No
   If yes, does child have glasses? Yes No
   If yes, describe when student should wear them:_____
   Will child require special seating in class? Yes No

3. Does child have any trouble with his/her ears or hearing? Yes No
   If yes, describe: _____
   Does child have hearing aids? Yes No
   Will child require special seating? Yes No

4. Does child get frequent colds or throat infections with a fever? Yes No
   Have child's tonsils been removed? Yes No

5. Was child ever diagnosed with pneumonia? Yes No
   If yes, when? _____

6. Has child ever had a convulsion or fit (seizure)? Yes No
   If yes, please list what type (epileptic, febrile). _____
   Medication child is on? _____
   What special restrictions, meds, or care will need to be provided at school for child? _____
   _____

7. Does child complain frequently of headaches? Yes No
   If yes, what medication or special care will be needed at school? _____

8. Has child ever had a fainting spell? Yes No
   If yes, was child treated by a doctor? Yes No
   Restrictions at school: _____

9. Is child under treatment for a skin problem (ex: Psoriasis, eczema)? Yes No
   What disorder and what treatment will be needed at school? _____

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10. Does child have a heart murmur that requires doctor's care? Yes No
    If yes, please list restrictions or special care needed at school _____

11. Does child have asthma or wheezing? Yes No
    If yes, list medication or inhaler(s) needed at school: _____

12. Does child have any bladder or kidney problems? Yes No
    If yes, please describe: _____
    Special care needed at school: _____

13. Has child been diagnosed with juvenile rheumatoid arthritis? Yes No
    If yes, please indicate care required at school? _____

14. Does child have frequent trouble sleeping? Yes No

15. Is child Diabetic? Yes No
    If yes, when was child diagnosed and what special care is needed at school? _____
    _____

16. Has child been diagnosed with ADD or ADHD, or another condition? Yes No
    If yes, please describe: _____
    Special care or treatment needed at school: _____
    Medications: _____

17. Has child been diagnosed with Tourette's syndrome? Yes No

18. Has child ever been treated for tuberculosis? Yes No

19. Has child ever been in the hospital or had an operation? Yes No
    If yes, indicate when and why: _____

20. Has child had other illnesses, accidents, or fractured bones? Yes No
    If yes, please describe: _____

21. Does child require any other restrictions, special care, or medications at school other than listed above?
    If yes, please describe: _____

REQUIRED PHYSICAL EXAMINATION FOR ENTRY INTO SCHOOL

Kindergarten and Sixth Grades

The Pennsylvania School Health law requires children upon original entry to school and in the sixth grade to have a complete physical exam.

_____

Signature of Parent/Guardian Date

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