Plum Borough School District
Nursing Services Department

Health History Information

Student's Name_____ Grade____ Date of Birth_____

List Allergies (to medications, food, environment, or insects):

Allergic to:	Type of Reaction:	Treatment Required:
_____	_____	_____
_____	_____	_____

List the Student's Current Medications*(include dosage, frequency, and time taken): _____
_____

Current Health Problems: _____

List Previous Hospitalizations and Surgeries: _____

Does the student have a history of:	Yes	No	Explain Yes Answers Here:
Asthma, Pneumonia, Recurrent Cough, Respiratory Illness	___	___	_____
Attention Deficit Disorder, Mental or Nervous Disorder	___	___	_____
Bone or Muscle Disorders, Previous Orthopedic Injury	___	___	_____
Born Prematurely, Developmental or Speech Delay	___	___	_____
Cancer, Blood Disorder, Inherited, Genetic Problems	___	___	_____
Diabetes, Other Endocrine Disorders	___	___	_____
Drug or Alcohol Problems	___	___	_____
Ear, Nose, Throat, Vision, Hearing Problems	___	___	_____
Gastrointestinal or Urinary Problems	___	___	_____
Head Injuries, Seizures, Dizziness, Concussion	___	___	_____
Heart Trouble, Murmur, Hole in heart, High blood Pressure	___	___	_____
Migraines, Frequent Headaches	___	___	_____
Scoliosis (curvature of the spine)	___	___	_____
Skin Conditions-Hives, Rashes, Eczema	___	___	_____
Do you have any concerns about your child's emotional well-being or behavior?	___	___	_____
Any Other Conditions – (not listed above)	___	___	_____

***Please keep in mind that if medications need to be given during school hours, Pennsylvania State Law requires a physician's order be provided to the school nurse. In addition, pharmacy medications must be in properly labeled safety containers.**

It is important to keep the school nurse informed regarding any changes in medication or any of the above information. Thank you for your cooperation in this matter.

Parent / Guardian Signature _____ Date_____