**PENN MANOR SCHOOL DISTRICT**
P.O. BOX 1001 MILLERSVILLE, PA 17551-0301
PHONE: 872-9500 FAX: 872-9505

HEALTH PROFILE

The information requested on this health profile will be kept confidential and will be included in your child's health record by the school nurse. We are asking for information in the areas of developmental history and early childhood history as we have found them to be helpful indicators of a child's readiness for learning. It will be shared with other school personnel (as teachers, principal, guidance counselors) only if it would be helpful in aiding their understanding of your child's performance in the classroom.

DATE ____________ SCHOOL ________________________ GRADE __________ TEACHER ______________________

CHILD'S FULL NAME ________________________________________________ NAME USED _____________________

BIRTHDATE ______________ PLACE OF BIRTH ________________________ BIRTH CERTIFICATE # _____________

ADDRESS __________________________________________________________ TELEPHONE # ___________________

NAME AND ADDRESS OF LAST SCHOOL ATTENDED ______________________________________________________

___________________________________________________________________ PHONE # _______________________

Father's Name (last, first, middle) _______________________________ Employer & Occupation ____________________

Mother's Name (last, first, maiden) ______________________________ Employer & Occupation ____________________

Father's Present Health Condition ___________ Birthdate _________ Birthplace _____________ Marital Status _________

Mother's Present Health Condition ___________ Birthdate _________ Birthplace _____________ Marital Status _________

Family Members at Home:

Brothers & Sisters Birthdate School Attends

________________________________________________________________________________________________

________________________________________________________________________________________________

Others Living in the Home

Chief Care by: _______ Parent ______Other (Specify) ____________________________________________________

I. IMMUNIZATIONS

| VACCINE | NUMBER OF DOSES REQUIRED BY LAW | DATES | BOOSTERS |
|---|---|---|---|
| *Diphtheria/Tetanus | 4 (last after age 4) | 1. | 4. |
| | | 2. | 5. |
| | | 3. | |
| *Polio | 3 | 1. | 4. |
| | | 2. | 5. |
| | | 3. | |
| *Measles (MMR recommended for both shots) | 2 (after age 1) | 1. | 2. |
| *Mumps | 1 (after age 1) | 1. | 2. |
| *Rubella | 1 (after age 1) | 1. | 2. |
| *Hepatitis B | 3 properly spaced | 1. | |
| Not less than 28 days between dose 1 and dose 2 | | 2. | |
| Not less than 4 months between dose 1 and dose 3 | | 3. _________________ | |
| *Varicella | 1 (or disease) | 1. (vaccine) ________ or date had disease _______ | |
| 1 dose for 12 months up to 13 years when vaccine given | | | |
| 2 doses if 13 years and older when vaccine given | | | |

(CONTINUED OVER)

Complications during labor and delivery (hemorrhaging, forceps, etc.) ______________________
Complications after birth (breathing, jaundice, feeding, etc.) ______________________
Medications or drugs used by mother during pregnancy (other than vitamins, iron) ______________
Baby's birth weight ____________ Birth defects ______________________

## III. EARLY CHILDHOOD HISTORY

At what age did the child sit alone without support? ______________________
At what age did the child walk alone without support? ______________________
At what age did the child begin to talk 2-3 words in short sentences? ______________________
At what age did the child get first tooth? ______________________

## IV. HAS YOUR CHILD HAD ANY OF THE FOLLOWING? (If possible, give date or child's age) *Describe below

| | | |
|---|---|---|
| Anemia ________ | Fever over 104° ________ | Food Allergy ________ |
| Pollen Allergy ________ | Bee Allergy ________ | Pneumonia ________ |
| Asthma ________ | Head Injury ________ | Pleurisy ________ |
| Chicken Pox ________ | Heart Disease ________ | Rheumatic Fever ________ |
| Convulsions ________ | Hepatitis ________ | Scarlet Fever ________ |
| Diabetes ________ | Hernia ________ | Seizures ________ |
| Ear Problems ________ | Influenza ________ | Tonsillitis ________ |
| Eczema ________ | Meningitis ________ | Positive Tuberculosis Test_____ |
| Encephalitis ________ | Mononucleosis ________ | Whooping Cough ________ |
| Hearing Problem ________ | Ear Tubes ________ date ______ | Ear Infection ________ |

***Describe anything checked above** ______________________
Other Serious Illnesses ______________________
Describe Hospitalization ______________________
Serious Accidents ______________________
Broken Bones, Joint or Muscle Problems ______________________

## V. HOW WOULD YOU DESCRIBE YOUR CHILD?

| | | |
|---|---|---|
| ________ Frequent colds | ________ Frequent pain in legs | ________ Many fears |
| ________ Sore Throats | ________ Frequent Stomach Aches | ________ Nervousness |
| ________ Nosebleeds | ________ Frequent Toothaches | ________ Tires Easily |
| ________ Persistent Cough | ________ Frequent Use of Toilet | ________ Cries Easily |
| ________ Ear Infection | ________ Wets or soils pants | ________ Speech Problems |
| ________ Running Ear | ________ Angers Easily | ________ Vision Problems |
| ________ Hearing Difficulty | ________ Worries a Great Deal | ________ Wears corrective Lenses |
| ________ Frequent Headaches | | |

## VI. MEDICAL AND DENTAL CARE

Child's Doctor ______________________ Phone # ____________
Child's Dentist ______________________ Phone # ____________
Other Physicians or Specialists ______________________ Phone # ____________

## VII. SPECIAL HEALTH NEEDS

1. Is your child going to a hospital, clinic, doctor or counseling now? Yes_____ No_____ Where__________
   Reason______________________
2. Apart from vitamins, is your child taking any medicines, tablets, or drugs on a continuous basis? Yes___ No__
   What ____________ Reason ______________________
3. Does your child need to take any medicine at school? No ___ Yes ___ Name of medicine ____________
4. Is your child allergic to anything such as foods, plants, insects, medicine? Yes ______ No ______
   What ____________ Describe reaction ______________________
5. Does your child need a special diet or have any food problems? Yes _____ No _____ Describe _________
   ______________________
6. Does your child have any special health needs or problems the school should know about? Yes ____ No ___
   Describe ______________________
7. Should your child have restrictions on play or physical activities? Yes ____ No ____ Describe __________
   ______________________

SIGNATURE OF PARENT / GUARDIAN ______________________ Date __________