SCSD TRANSFER FORM: STUDENT HEALTH HISTORY

STUDENT FULL NAME: ____ GRADE: ________________________

BIRTHDATE: ___________________________ BIRTHPLACE: ____

TRANSFERRING FROM: ____ LOCATED IN STATE OF: _________
School name/address

HAS THIS STUDENT EVER ATTENDED SCHOOL IN PENNSYLVANIA BEFORE? Circle: **YES / NO**

IS SO, WHEN AND WHERE? ____

*** STUDENT HEALTH HISTORY ***

Does your child have any medical history, current medical conditions, or ever been hospitalized? Circle: **YES / NO**

If yes, please specify the problem(s) & dates: ____
____
____
____

Does your child take any medications, herbals, or supplements? Circle: **YES / NO**

If yes, please specify **names** and **doses**: ____
____
____

Will your child need to take medications or receive medical treatments in school? Circle: **YES / NO**

(If yes, please see the medication administration policy for proper medication procedure)

Does your child have any food or medication allergies? Circle: **YES / NO**

If yes, please specify the product & the problem(s): ____
____

Does your child have any special dietary needs or issues? Circle: **YES / NO**

Please specify: ____
____

Does the family have insurance or some way to pay for medical expenses? Circle: **YES / NO**

Any other health concerns the school should be aware of (ex: hearing or vision problems, activity restrictions, speech difficulties, frequent illness, nosebleeds, headaches, broken bones, stomachaches, fainting spells, developmental delays, emotional or behavioral problems, etc)? ____
____
____
____

Please list the name and phone number for your child's health care providers & date of most recent visit (if applicable):

Primary Care Provider: ____date: __________________
Dentist: ____date: __________________
Eye Doctor/Specialist: ____date: __________________
Other Specialist: ____date:__________________

***** FAMILY HISTORY *****

Household unit (please include any special relationships, such as step, adoptive, foster, or grand parents or children)

RELATIONSHIP	BIRTHDATE	FULL NAME (Include maiden name)	LEVEL OF EDUCATION	OCCUPATION
Mother				
Father				
Brother(s)				
Sister (s)				
Other				

Family History: Please provide a brief list of any family medical or other problems (ex: diabetes, seizures, asthma, dependencies, recent death of a family member, mental health issues, unemployment, divorce, custody issues, etc)

Parents:

____

Siblings:

____

Grandparents:

____

Other:

____

____

Thank you for all the information for your child's health record, please let us know of any changes to your child's health status throughout the year and contact us with any questions or concerns you may have.

____ ____________________

Parent/Guardian Signature Date