



Shippensburg Area School District

Name: _____ Date of Birth _____ Grade _____

Student Health History

Health Conditions (Please check any that apply and provide details on the back of this form)

Asthma	Heart problems
Attention Deficit Disorder	Bleeding disorders
Birth or congenital malformation	Kidney/Bladder problems
Bone or joint deformities	Tourettes / Nervous Tics
Cerebral palsy	Peanut/Nut allergy
Cystic Fibrosis	Bee sting allergy
Diabetes	Medication allergy : _____
Behavioral/Mental Health Issues	Food allergy : _____
Epilepsy/Seizure Disorder	Other allergy: _____
Headaches/migraines	Other: _____
Hearing problems	Other: _____

If you checked any allergy, please describe the symptoms your child has had with the allergic reaction and Emergency measures we need to take: _____

Current Medications: _____

Other Health information (hospitalizations, surgeries, etc.) _____

Any changes in your family status or other situations that may affect your child? _____

List Brothers and Sisters names, age and grade: _____

My child may be given Acetaminophen (Generic Tylenol) at school, as needed, for pain or fever. ___Yes ___ No

Signature of Parent _____

Date _____