THE SCHOOL DISTRICT OF HAVERFORD TOWNSHIP
50 E. Eagle Road, Havertown, PA 19083
610-853-5900

SCHOOL HEALTH RECORD

(*to be completed by parent or guardian*)

Student's name:	Date of birth:
Address:	Telephone No.
	School:
Father's name:	Mother's name:

CHILDHOOD ILLNESSES

Check all illnesses your child has had

- ❑ Chicken Pox
- ❑ Whooping Cough
- ❑ Scarlet Fever
- ❑ Rheumatic Fever
- ❑ German Measles
- ❑ Measles
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Pneumonia
- ❑ Mumps
- ❑ ______________________
- ❑ ______________________

Operations: ____

Allergies: ____

Ear infections: ____

Bee sting reaction (*circle one*) **MILD** **SEVERE** **NONE**

Is your child presently under medical treatment? (*circle one*) **YES** **NO**

List any illnesses or health problems which you or your family physician feel should be made known to

school authorities: ____

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Signature of Parent or Guardian

____
Date

DISTRIBUTION: School Nurse