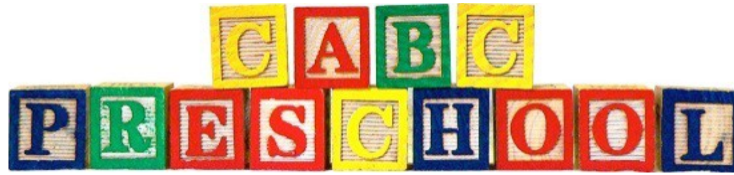

730 Menges Mills Road Spring Grove, Pa 17362
717-225-1876 phone, 717-225-6644 fax

Student Health Form

Student's name: ___________________________________ Date of birth: __________________

Immunizations	Dates Administered
Polio (OPV)	__________, __________, __________
MMR	____________
DPT	__________, __________, __________, __________
HIB	__________, __________, __________, __________
Varivax (varicella)	____________
Hepatitis B	__________, __________, __________

1. Does this child have any significant physical or emotional disabilities?

   ____

   Please specify the special needs of this child while in the care of the preschool staff.

   ____

2. Does this child have dietary restrictions or food allergies? ____________________________

   If yes, please specify the foods to be avoided and the symptoms and/or degree of allergice reaction, and specific treatment in the event of accidental consumption.

   ____

   ____

PLEASE TURN OVER »»»

3. Does this child have seasonal allergies, asthma, or other respiratory complications about which the preschool teacher should be aware of?

____

____

4. List any other precautions or limitations about which the preschool teacher should be aware. ____

5. Has this child ever been tested or recommended for specialized testing for vision, hearing, speech, or behavior? ____

6. Does this child take any medication on a routine basis? _______________________

   If yes, please specify med(s), reason prescribed, and any other information that would be beneficial to the preschool staff.

   ____

7. Physician's comments:____

____

This is to verify that the above named child is free from communicable disease and is able to participate in regular preschool activities (with exceptions noted above).

Physician's signature: ________________________________ Date: ___________________