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) _____

PROOF OF IMMUNIZATIONS MUST BE PRESENTED IN ORDER TO ENROLL A STUDENT IN SCHOOL IN PENNSYLVANIA,

IMMUNIZATIONS REQUIRED BY THE COMMONWEALTH OF PENNSYLVANIA FOR ADMISSION TO SCHOOL

Diphtheria & Tetanus: (DTap, DTP, Td, or DT)	**Four properly** spaced doses with one of the doses administered on or after the fourth birthday.
Polio:	**Three** doses (IPV or OPV).
Measles:	**Two** properly spaced doses with the first dose given at 12 months of age or older. (The Department of Health recommends the combined MMRII vaccine).
Mumps:	**One** dose administered at twelve months of age or older. (Department of Health recommends the combined MMRII).
Rubella:	**One** dose administered at twelve months of age or older. (Department of Health recommends the combined MMRII).
Hepatitis B:	**Three** properly spaced doses.
Varicella: (chickenpox)	**One** dose or proof of having had the disease for Incoming kindergarten and 7th grade under 13 years. (**Two** doses for children 13 and older).

DEVELOPMENTAL HISTORY

Length of pregnancy _____
Complications during pregnancy (high fever, illnesses, injury, etc.) _____
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 _____

- 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? _____

- 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 _____

- 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
_____ Frequent Headaches		Lenses

- MEDICAL AND DENTAL CARE

Child's Doctor _____ Phone # _____
Child's Dentist _____ Phone # _____
Other Physicians or Specialists _____ Phone # _____

- 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? Yes ___ No___ 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