Healthcare Questionnaire

Saints Philip and James Parish School
721 East Lincoln Highway
Exton, PA 19341
610-363-6530
school.sspj.net

Date_____

Child's Full Name _____ Male ☐ Female ☐
(Last) (First) (Middle)

Birth Date _____ Child lives with: _____
(MM/DD/YY)

Mother's Name _____ Maiden Name _____

Father's Name _____ Guardian Name _____

Address_____ Zip_____

Home Phone_____ Work Phone_____Cell Phone_____

Child's School History

Grade Entering_____ School _____

Previous School Attended: Name_____None_____

School's Location (City, State)_____

Dates of Attendance (Month, Year): From_____To_____

Number of Days per Week: 2 Days ☐ 3 Days ☐ 4 Days ☐ 5 Days ☐

Child's Health History

Child's Birth Weight_____ pounds _____ounces

Problems with Pregnancy (Optional) No ☐ Yes ☐ Explain _____

Any Health Conditions Problems? No ☐ Yes ☐ Explain _____

On any Medication? No ☐ Yes ☐ Explain _____

Serious Illness or Accidents? No ☐ Yes ☐ Explain _____

Has Your Child been Hospitalized? No ☐ Yes ☐ If Yes at what Age _____ for how Long _____

Why? _____

Has Your Child had Chicken Pox Disease? No ☐ Yes ☐ Date _____

Date of Most Recent Physical Exam _____ Name of Doctor _____

Date of Most Recent Dental Exam _____ Name of Dentist _____

Does Your Child have any Allergies? No ☐ Yes ☐ Food _____Medication_____

Hearing

Was Hearing Ever Tested? No ☐ Yes ☐ Hearing Difficulty? No ☐ Yes ☐ Describe _____

Ear Infections? No ☐ Infrequent (1-3/year) ☐ Frequent (4 +/year) ☐ Prolong (10-14 days+) ☐

Hearing

Has Your Child had an Eye Test? No ☐ Yes ☐ Results _____

Any Visual Problems? No ☐ Yes ☐ Describe _____

Over

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Tuberculin Risk Evaluation

Please read the "High Tuberculosis risk" situations listed below. If your child has a high risk for tuberculosis, the school nurse will refer your child to your Health Care Provider for further testing.

- He/she is living with a person with infectious TB
- He/she has had extensive travel in high risk tuberculosis areas
- He/she has an HIV infection or another condition that is a high risk for TB disease
- You think your child might have TB disease
- Your child is foreign born from a country where TB disease is very common (most countries in Latin America and the Caribbean, Africa, and Asia, except for Japan)
- He/she is living with an IV drug user
- He/she lives or has lived in a communal sitting where TB disease is common (most homeless shelters, migrant farm camps, orphanages)
- He/she is living with a person who recently has been in prison and/or jail, or a nursing home

Is your child at risk for Tuberculosis? No ☐ Yes ☐ Explain _____

Your child is being referred to your Health Care Provider for further Tuberculin testing. No ☐ Yes ☐

Examinations and Tests – Kindergarten through Eighth Grade

I understand that state law requires physical examinations (Grades Kindergarten, First, Sixth and Eighth) and dental examinations (Grades Kindergarten, First, Third and Seventh). If these are not performed by the student's private physician or dentist, please contact the school.

State law also requires school nurses to perform yearly screening tests for growth, body mass index, vision, color vision, hearing, and scoliosis. I understand that I will be informed of any abnormal results of health examinations and tests given to my child by the School Nurse.

Student Health Record

I understand that Student Health Records are kept confidential. The information in the Student Health Record is shared with school personnel only when that information is relevant to the education of the child. As with all student records, the Student Health Record is shared with persons outside of the school district only with the written consent of parents/guardians. The Student Health Record does follow the student as they transfer to other public and private schools.

Immunization Permission

The West Chester Area School District in coordination with the Chester County Health Department is establishing a means of tracking immunizations for children. By tracking the immunizations, any school district needing immunization information would be able to obtain this data immediately.

As parent and/or guardian of the minor child, _____ I hereby authorize the release of the medical immunization record only, past, and present, of said minor for the purposes of inclusion in the Health Department immunization tracking system, provided that said information shall at all times be held in confidence, excepting the Health Department and the designated health care provider or insurer. If you have any questions please call the Chester County Health Department at (610) 344-6252.

_____ _____

Date Signature Parent/Guardian