Millcreek Township School District
3740 West 26th Street
Erie, PA 16506
(814) – 835 – 5300

Student Health History
For **ALL** Prospective Students
Completed by Parent or Guardian
Version 12.2

MTSD OFFICE USE ONLY		
School:	**Today's Date:**	**School Entry Date:**
PA Secure ID #:	**MTSD ID #:**	**Homeroom:**

Student Information — Section A

Student's Last Name:	**First Name:**	**Sex:**	**Birth Date:**
Address:			
Last School Attended:		**State:**	**Entering Grade:**
Student lives with (check all that apply): ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian			
Father's Name:	**Mother's Name:**		
Guardian's Name (if applicable)**:**	**Step Parent Name** (if applicable) **:**		
Home Phone: – –	**Cell Phone:** – –	**Work Phone:** – –	

Student Health and Medical History — Section B

Family Doctor Last Name:	**Telephone:** – –

Family Dentist Last Name:	**Telephone:** – –

MEDICAL HISTORY			
Condition	**Yes**	**No**	**Age**
Allergy – Bee Sting	☐	☐	
Allergy – Food	☐	☐	
If Yes, identify food(s):			
Allergy – Other	☐	☐	
If Yes, identify food(s):			
Asthma	☐	☐	
Bed Wetting	☐	☐	
Chicken Pox	☐	☐	
Chronic Illness	☐	☐	
Diabetes	☐	☐	
Frequent Colds	☐	☐	

MEDICAL HISTORY			
Condition	**Yes**	**No**	**Age**
Frequent Ear Aches / Infection	☐	☐	
Heart Trouble	☐	☐	
Kidney Trouble	☐	☐	
Pneumonia	☐	☐	
Rheumatic Fever	☐	☐	
Scarlet Fever	☐	☐	
Seizure Disorder	☐	☐	
Tuberculosis	☐	☐	
Whooping Cough	☐	☐	
Other	☐	☐	
If Yes, explain:			

(OVER)

MEDICAL HISTORY CONTINUED

Is your child's vision impaired? ☐ Yes ☐ No If Yes, is your child under a doctor's care? ☐ Yes ☐ No

If Yes, explain the condition:

Is your child's hearing impaired? ☐ Yes ☐ No If Yes, is your child under a doctor's care? ☐ Yes ☐ No

If Yes, explain the condition:

Does your child have any speech or language issues? ☐ Yes ☐ No If Yes, is he/she being treated? ☐ Yes ☐ No

If Yes, explain:

Does your child have any urinary tract or bowel incontinence problems that might require extra care or preparation in school? ☐ Yes ☐ No

If Yes, explain:

Does your child have any other physical illness or impairment that might affect his/her normal participation or progress in regular school programs? ☐ Yes ☐ No

If Yes, explain:

Does your child have any mental, emotional, or behavioral issues that might affect his/her normal participation or progress in regular school programs? ☐ Yes ☐ No

If Yes, explain:

Does your child have any health problems which might require emergency treatment while at school? (seizures, bee-sting or food allergies, bleeding or heart problems) ☐ Yes ☐ No

If Yes, explain:

Is your child currently under a doctor's care ? ☐ Yes ☐ No

If Yes, explain:

Are there components of this care that would restrict your child's participation in any physical activity at school? ☐ Yes ☐ No

If Yes, explain:

In addition, if you answered Yes to the above, please submit a statement from your doctor detailing the nature and the duration of the restriction.

Is your child currently taking prescribed medication? ☐ Yes ☐ No

If Yes, please specify by name: _____ _____ _____

Medication must be administered during school hours? ☐ Yes ☐ No

If Yes, you must read Policy 210 – Use of Medications and complete the Authorization for Medication to be taken during School Hours Form.

Describe identifiable birthmark, scar, or other distinguishing features:

I grant MTSD medical staff permission to share health information to faculty and staff on a need to know basis? ☐ Yes ☐ No

Parent Signature: _____ **Date:**_____