Mount Carmel Area School District

Child's Name:_____ Grade:_____ Age:_____

Health History

Does the child have any allergies (include food/ medication/ environment)? Yes or No

Food:_____ **Reaction** _____
Medication:_____ **Reaction** _____
Environmental/Seasonal:_____ **Reaction:**_____

Does the student require medications/ EpiPen for any of the above allergies? Yes/ No

Has the child ever had any of the following illnesses/problems?

	Yes	No	
Pneumonia	☐	☐	
6 colds or throat infections within a year	☐	☐	
Has the child has their tonsils removed?	☐	☐	
Trouble hearing or frequent ear infections	☐	☐	
Trouble with eyes or seeing	☐	☐	
Child wears glasses	☐	☐	
Will require special seating in classroom	☐	☐	
Had a fainting spell	☐	☐	If Yes- Age of Last_____
Heart Murmur	☐	☐	Any restrictions? Yes/ No
Frequent Diarrhea	☐	☐	
Constipation	☐	☐	
Bladder/Kidney Problems	☐	☐	
Skin Problems/ Eczema	☐	☐	
Asthma/Wheezing	☐	☐	
Bleeding Disorders	☐	☐	
Lead Poisoning	☐	☐	
Concussion or other head injury	☐	☐	
Diabetes	☐	☐	If yes- Age _____
Seizures	☐	☐	Please Describe_____
Speech Problems	☐	☐	Please Describe_____
Receiving Speech Therapy	☐	☐	
Diagnosed with ADD or ADHD	☐	☐	If yes- Age____
	Medications:_____		
Any Serious Illnesses	☐	☐	Please Describe_____
Depression	☐	☐	
Anxiety	☐	☐	
Hospitalizations	☐	☐	Please Describe_____
Operations	☐	☐	Please Describe_____
Accidents	☐	☐	Please Describe_____
Broken Bones	☐	☐	Please Describe_____
Trouble with teeth/ Cavities	☐	☐	
Autism/ Asperger's	☐	☐	
Cerebral Palsy	☐	☐	
Cancer	☐	☐	

Medical Professional Information

Primary Care Physician
Name:_____ Date of Last Visit:_____
Dentist
Name:_____ Date of Last Visit:_____

Does your child take any medical regularly/ daily for any health concerns? Yes/ No
If Yes, what is the name/ dose of the medication?:_____

Will your child need to take medication during school hours? Yes/ No

If YES- A medication permission form MUST be completed for ALL medications to be administered during school hours. This form must be updated when there is a change of dose/ medication and/or YEARLY.
You can find the form here: Medication Permission Form

Please indicate any of the Following Diseases that the child's parents, brothers, sisters, grandparents, has experienced in the past:

Allergy
Anemia
Asthma
Arthritis
ADD/ADHD
Cancer
Drug Addiction
Alcohol Addiction
Gastrointestinal Disorder
Seizures
Sickle Cell Anemia
Vision or Hearing Problems
Kidney Disorder
Migraine headaches
Diabetes
Seizures/ Epilepsy
Heart Disease/ Heart Murmur
High Blood Pressure
Blood Disorder
Bleeding Disorder
Other Inherited Family Disease:

Please add any additional information:

I certify the above information is correct. By completing this form, I give my permission for the Mount Carmel Area School District to forward health information with faculty/staff/ food service/ bus drivers etc on a need-to-know basis. This allows the District staff to alert staff about health concerns/ allergies and to give records/ information to EMS in the case of an emergency.

Parent/ Guardian Signature:_____Date:_____
Phone number:_____ Email Address:_____