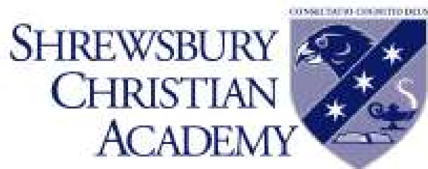

701 Windy Hill Road
New Freedom, PA 17349
Phone: 717-235-5763
Fax: 717-235-5357
Email: info@scaonline.org

Medical Health History

Student Information

Student's Name ____
Last *First* *Middle*

Home Phone ____________________ Gender ☐ Male ☐ Female Grade ________

Home Address ____

Date of Birth ____________________ Place of Birth *(City & State)* ________________

Student's Physician ______________________________ Physician's Phone __________

Physician's Address ____

Student's Dentist ______________________________ Dentist's Phone __________

Dentist's Address ____

Family Information

Father ________________________ Mother ________________________

Brothers & Sisters in Household *(please list names and birthdays)*:

____

____

Medical Information

Please check if your child has had any of the following. Please include date, if possible.

____ Mumps
____ Polio
____ Strep Throat
____ Pneumonia
____ Chicken Pox
____ German Measles/3 Day measles
____ Whopping Cough
____ Rheumatic Fever
____ Rubella
____ Other ______________________________
____ 10 day measles
____ Scarlet Fever
____ Meningitis
____ Ear Infections

VACCINE Circle appropriate item	Enter Month, Day, and Year Each Immunization Was Given DOSES				
Diphtheria and Tetanus (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, Diphtheria, and Acellular Pertussis (Tdap)*	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - Mumps - Rubella (MMR)	1 / /	2 / /	or Measles Serology Date Titer		
Varicella (Vaccine or Disease)	1 / /	2 / /	Rubella Serology Date Titer		
Meningococcal (MCV)*	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		
Other	1 / /	2 / /			

*Age appropriate dose of MCV and Tdap are required for entry into 7th grade.

Medical Information *(con't)*

Has your child had any operations, serious illnesses, or ever been hospitalized? ☐ Yes ☐ No

If yes, please explain ______________________________

Is your child under any medical treatment at this time? ☐ Yes ☐ No

If yes, please explain ______________________________

Is your child taking any medications at this time (please submit a *Request for Medication Administration Form*)? ☐ Yes ☐ No

If yes, please explain ______________________________

Does your child need any emergency medication while in school (please submit a *Request for Medication Administration Form*)? ☐ Yes ☐ No

If yes, please explain ______________________________

What was your child's weight at birth? ________ lbs ________ ozs

Were there any defects at birth? ☐ Yes ☐ No

If yes, please explain ______________________________

Please use the space provided to list any other medical concerns that the school should know about your child.

Father's/Guardian's Signature ______________________________ Date ____________

Mother's/Guardian's Signature ______________________________ Date ____________