MONTOURSVILLE AREA SCHOOL DISTRICT
HEALTH INFORMATION

STUDENT'S LEGAL LAST NAME	FIRST NAME	MIDDLE

Please attach a copy of the student's immunization record OR religious exemption at time of registration

SPECIAL HEALTH NEEDS (Circle Yes of No)

Has the child ever had any serious illness or operations? Yes No

What? _____ Date _____

Besides vitamins, is the child taking any medication: prescription and/or over-the –counter? Yes No

What? _____ Why? _____

Will the child need to take any medication: prescription and/or over-the-counter while at school? Yes No

What? _____ Why? _____

Is the child allergic to anything such as foods, plants, insects or medicine? Yes No

What happens when the child has an allergic reaction? _____

Does the child take any medication if he/she has a reaction? Yes No

If so, what is the medication? _____

Has the child ever had a seizure? Yes No

Type of seizure _____ How many? _____ Last seizure _____

Does the child require a special diet? Yes No

Give details _____

Does the child have any special health needs or problems the school should be aware of? Yes No

What? _____

_____

Has the child had any illnesses, accidents, concussions, or broken bones? Yes No

When? _____ What was the problem? _____

_____

Name of dentist _____ Date of last visit _____

Name of physician _____ Date of last visit _____

_____ _____

Parent/Guardian Signature Date