

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

STUDENT HEALTH STATUS

LAST NAME	FIRST NAME	BIRTH DATE
SCHOOL NAME	ROOM/BOOK	GRADE
		DATE OF ISSUE

■ Please complete this form and return it to your school nurse immediately for the safe care of your child.

To Parent/Guardian:

Your child's health record/history indicates that he/she has been under care for the following health problem(s):

1. Does the student's health problem(s) still exist? _____

2. Does he/she have other health problems? Yes No If yes, what are they? _____

3. Does he/she take medicine?
Yes No
If yes, please give name of medicine,
dosage, and time(s).

Medicine	Dosage	Time

4. Does he/she regularly receive treatment/therapy or undergo any testing procedures? _____
If yes, please indicate kind and how often taken _____

5. Name of doctor, clinic or health center providing care for the student _____

Address _____

Phone # _____ Fax # _____ Date of last visit _____

6. Insurance Provider _____

► **CONTACTS:**

Parent/Guardian: _____ Home Phone: _____

Work Phone: _____ Cell/Pager: _____

Parent/Guardian: _____ Home Phone: _____

Work Phone: _____ Cell/Pager: _____

Emergency Contact #1: _____ Phone #: _____

Emergency Contact #2: _____ Phone #: _____

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian _____ Date _____

TO SCHOOL STAFF: SEE REVERSE SIDE FOR EMERGENCY CARE

SCHOOL NURSE	PHONE #
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