Office Use Only
Registered By: _____ Date:_____
Registration Completed at building: _____
Form complete: Yes _____ No _____
Assigned to Grade: ____ Teacher: _____

Hanover Public School District
Medical History
2014-2015

Dear Parent or Guardian:

A state immunization law requires that all children have the vaccines listed below prior to entering school for the first time. In order to comply with the law, the district requires an accurate immunization record of all children entering school.

Child's Name _____ Date of Birth _____ Male Female

Address _____Present Grade _____

Family Physician _____Family Dentist _____

Father's Name _____Guardian's Name _____

Mother's Name _____Maiden Name _____

Attach Copy of Immunization Record.
All students in grades indicated will need the following immunizations to start school:

4 DTP or TD (Diphtheria/Tetanus/Pertussis) with one vaccine on or after the 4th birthday (K-12)
1 Tdap (Boostrix or Adacel) (Gr 7)
3 Polio (K-12)
2 MMR (Measles/Mumps/Rubella) (K-12)
3 Hepatitis B (Properly spaced) (K-12)
2 Chicken Pox vaccine or had the disease (K-12)
1 Menactra (Meningitis) (Gr 7)

HEALTH SURVEY

Is your child covered by health insurance? Yes No

Has your child had any of the following? (If any, please list.)
Health Problems: _____See Back_____

Counseling: _____

Medications_____

Date of last physical exam: _____ Done by Dr._____

Dental Problems: _____ Done by Dr._____

I have been notified that state law requires my child to have a physical and dental examination to enter school. I understand that if I do not return the completed private physician and private dentist forms, my child will be examined by a school physician and/or dentist and may be transported to another building for this examination.

Parent/Guardian Signature: _____ Date: _____

Please complete the back of this form.

HEALTH HISTORY

Name of Student _____ Grade _____ HR _____

Please complete the following information and return to the school district:
Does your child have any of the following conditions? Mark yes or no and explain if necessary.

CONDITION	NO	YES	EXPLANATION
1. Allergies	_____	_____	_____
Severe Allergies (Epipen)	_____	_____	_____
2. Arthritis	_____	_____	_____
3. Asthma	_____	_____	_____
4. ADD/ADHD	_____	_____	_____
5. Birth Defects/Developmental Problems	_____	_____	_____
6. Bleeding Disorders/Anemia	_____	_____	_____
7. Cardiovascular condition	_____	_____	_____
8. Connective Tissue Disorder	_____	_____	_____
9. Cystic Fibrosis	_____	_____	_____
10. Cerebral Palsy	_____	_____	_____
11. Diabetes	_____	_____	_____
12. Eating Disorder/Diagnosed	_____	_____	_____
13. Endocrine Disorder	_____	_____	_____
14. Stomach/Intestinal Problems	_____	_____	_____
15. Kidney/Urinary Problem	_____	_____	_____
16. Hearing Problems/Infections/ Hearing Aids/ Tubes	_____	_____	_____
17. Heart Problems	_____	_____	_____
18. High Blood Pressure	_____	_____	_____
19. Immunosuppressive Problem	_____	_____	_____
20. Tumors/Cancer/Type	_____	_____	_____
21. Neurological Disorders	_____	_____	_____
22. Orthopedic/Bone Problem	_____	_____	_____
23. Scoliosis	_____	_____	_____
24. Psychiatric/Emotional	_____	_____	_____
25. Seizure/Convulsion Disorder	_____	_____	_____
26. Sickle Cell Disease	_____	_____	_____
27. Vision/Color Deficit (Glasses/Contacts)	_____	_____	_____
28. Weight Disorder	_____	_____	_____
29. Speech Disorder	_____	_____	_____
30. Absence of Fingers/Toes/Other Organs	_____	_____	_____
31. Operations	_____	_____	_____
32. Concussions/Head Injuries	_____	_____	_____
33. Serious Accidents/Burns, etc.	_____	_____	_____
34. **Chicken pox (Varicella)**	_____	_____	(Age and/or Date)_____

Is your child presently under medical treatment? NO _____ YES _____
If yes, please state reason: _____
Do you wish to schedule a conference with the school nurse to discuss any of the above? _____

Signature of Parent/Guardian: _____ Date: _____