Office Use Only: School ID# _____

PALCS Health Services
1332 Enterprise Drive
West Chester, PA 19380
Phone: 610-701-3333, ext. 1404
Fax: 610-692-2783

School Health Information

Name of Child: _____ DOB:_____

Street: _____City:_____Zip:_____

Primary Phone: _____ Alternate Phone: _____ Sex: ☐M ☐F Grade: _____

The School Health Act requires that **Physical Examinations** for **new students** in K or grade 1 and students in grades **6 and 11** be provided to schools. If you prefer for the physical exam to be done by your family doctor, a Private Physical form is available for completion by your child's physician. Completed copies must be returned to the school nurse by **November 1, 2016, or notification of scheduled physical to be received before March 1, 2017.**

The School Health Act also requires that **Dental Examinations** for **new students** and students in grades **K, 3, and 7** be provided to schools. If you prefer for the dental exam to be performed by your family dentist, a Private Dental form is available for completion by your child's dentist. Completed copies must be returned to the school nurse by **November 1, 2016, or notification of scheduled dental exam to be received before March 1, 2017.**
*****If you choose to have your child evaluated by the school physician/dentist, you will be contacted with available exam dates. NO IMMUNIZATIONS WILL BE ADMINISTERED DURING SCHOOL PHYSICAL EXAMS.**

▪ ***For new students entering K or Grade 1 and students going into grades 6 and 11, I prefer to have my child examined by:***

☐Our Family Doctor ☐West Chester School Doctor

▪ ***For new students entering K or Grade 1 and students going into grades 3 and 7, I prefer to have my child examined by:***

☐Our Family Dentist ☐West Chester School Dentist

Does your child wear glasses? ☐Yes ☐No Contacts? ☐Yes ☐No

Does your child have a hearing problem? ☐Yes ☐No Hearing aid? ☐Yes ☐No

Does your child have allergies? ☐Yes ☐No If YES, please list (i.e. insects, bees, food, environment, medications, etc.)

_____

_____

Does your child have asthma or reactive airway disease? ☐Yes ☐No

Is your child taking any medications? ☐Yes ☐No If YES, Please list below:

- Non prescription_____
- Prescription_____
- Reason for medication_____

Has your child ever had seizures? _____ Date: _____ Cause: _____

Does your child have any special health needs or problems? ☐Yes ☐No If YES, please explain:

_____

Has your child ever had a serious operation, illness, accident or concussion? ☐Yes ☐No Date: _____

If YES, please explain:_____

Has your child had:	**Disease /Date**	**Disease/Date**	**Disease/Date**
Please circle and,	Chickenpox	Mumps	Hepatitis
if possible,	Measles	Scarlet Fever	Tuberculosis
provide dates	Whooping Cough	Rheumatic Fever	German Measles

*** Please send dates of newly administered immunizations so that we can update your child's health record.**

Parent/Guardian Signature:_____ **Date:**_____