H511 336 (Rev 5/02)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

DATE ________________ 20 ______

NAME OF SCHOOL ______________________________ GRADE ______ HOMEROOM ________

NAME OF CHILD Last First Middle	DATE OF BIRTH	SEX ☐ ☐ M F

ADDRESS

No and Street | City or Post Office | Borough or Township | County | State | Zip Code

MEDICAL HISTORY

IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, And Year Each Immunization Was Given DOSES				BOOSTERS & DATES
Diphtheria and Tetanus	1 / /	2 / /	3 / /	4 / /	5 / /

Significant Medical Conditions (✓)

Condition	Yes	No	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Diabetes Mellitus	☐	☐	
Hearing Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	