

## Student Health Form

*Please have the medical provider fill out the form.*

Trinity Nursery School  
717-637-2126

116 York Street  
trinitynurseryhanover@gmail.com

Hanover, PA 17331

Student's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Immunizations	Dates Administered
Polio (OPV)	
MMR	
DPT	
HIB	
Varivax	
Hepatitis B	

1. Does this child have any significant physical or emotional disabilities? If yes, explain.

Please specify the special needs of this child while in the care of the nursery school staff.

2. Does this child have dietary restrictions or food allergies?  
If yes, please specify the foods to be avoided and the symptoms and/or degree of allergic reaction, and specific treatment in the event of accidental consumption.
3. Does this child have seasonal allergies, asthma, or other respiratory complications about which the nursery school staff should be aware?  
If yes, specify prescribed treatment.

Will treatment during school hours be necessary?

4. List any other precautions or limitations about which the nursery school staff should be aware.
5. Has this child ever been tested or recommended for specialized testing for vision, hearing, speech, or behavior?
6. Does this child take any medication on a routine basis?  
If yes, please specify med(s), reason prescribed, and any other information that would be beneficial to the nursery school staff.

7. Physician comments (use reverse if necessary)

*This is to verify that the above named child is free from communicable disease and is able to participate in regular nursery school activities (with exceptions noted above).*

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_