HAMPTON-DUMONT COMMUNITY SCHOOL DISTRICT HEALTH REVIEW

ELEMENTARY STUDENT

(*This information is CONFIDENTIAL but may be shared with appropriate school personnel as needed*)

Student Name:____ Birth Date:____________ Grade:_______ Teacher_______________

HEATH CONCERN	YES	NO	EXPLAIN	HEALTH CONCERN	YES	NO	EXPLAIN
ADD/ADHD				Seizures			
Asthma/Breathing				Skin			
DentaL				Sleeping			
Diabetes				Speech			
Headaches				Stomach/bowel			
Hearing				Vision/glasses/contacts			
Heart				Weight			
Kidney/bladder				Other			

List your child's allergies: Food:___________________________Medicine:_________________Environmental:____________________________________

Medications (name, dose, time):____Doctor:_________________________

List any illnesses, operations, or accidents your child has had in the past year:____

List any emotional, social or other conditions that might affect your child's school performance:____

List any other health concerns you would like the nurse to know about:____

International travel: My child has been out of the United States during the past year: Yes_____No______Name of Country____________________________

Complete for KINDERGARTEN/EARLY CHILDHOOD	YES	NO	EXPLAIN
Was this a full term pregnancy?			
Were there difficulties during pregnancy?			
Were there difficulties after birth?			
Did the sit alone before 7 months? Walk alone by 15 mos?			
Did the child say words by 1 ½ years of age?			
Did the child have frequent upper respiratory infections? Ear infections?			

Health Insurance Information: Private__________ Medicaid __________ HAWK-I __________ No insurance ___________Applying for: ________________

Parent Signature:____Date:____________________________________