Kutztown Area School District

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CENTRAL ADMINISTRATION

OFFICE OF REGISTRATION, RESIDENCY AND GUARDIANSHIP

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~Maximize potential, embrace change, create the future~

CONFIDENTIAL HEALTH HISTORY

☐ Greenwich Elementary ☐ Kutztown Elementary ☐ Middle School ☐ High School

To Parent or Guardian:
In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you, which will also be helpful in meeting your child's health needs.
I give my permission for release of information on this form for confidential use in meeting my child's health and educational needs.

____________________________________ ____________________
Signature of Parent/Guardian Date

Child's Full Name ____ ☐ Female ☐ Male
Last First Middle

Birth Date ________________ Place of Birth ________________________________

Home Address ____

Phone Number ______________________________

Father/Guardian Name ____________________ Mother/Guardian Name ____________________

Please check answers to the following questions in columns on the left.
(Explain all "yes" answers in the space provided)

Yes	No	
☐	☐	Do you have any concerns about your child's general health (eating, sleeping habits, weight, teeth)?
☐	☐	Does your child have any other specific illness or problems?
☐	☐	Does your child have any allergies (food, insects, medication, etc.)?
☐	☐	Are emergency medications required for allergies?
☐	☐	Does your child take any medications (daily or occasionally)?
☐	☐	Does your child need to take medication at school?
☐	☐	Does your child need a special diet or have any food problems?
☐	☐	Does your child have any problems with vision, hearing or speech (glasses, ear tubes, hearing aids)?
☐	☐	Has your child had any hospitalization, operation, or major illness (specify problem)?
☐	☐	Has your child had any significant injury or accident (specify problem)?
☐	☐	Has your child had any head injury or diagnosed concussion?
☐	☐	Does your child have any special health needs or problems the school should know about?
☐	☐	Does your child have any behavioral, psychological concerns, or is under the care of a therapist?
☐	☐	Should your child have restrictions on play or physical activities?

Please explain "yes" answers here. Include year and/or child's age at the time of illness/injuries.

____

____

____

STUDENT HEALTH/DEVELOPMENTAL HISTORY

History of Pregnancy and Birth
(Please circle Answer)

♦	Did the mother have any illness during pregnancy?	YES	NO
♦	Did the mother take any medicines or drugs (other than vitamins or iron) during pregnancy? What?______	YES	NO
♦	Was the mother or family under unusual strain during pregnancy?	YES	NO
	Cause ______		
♦	Was the mother hospitalized?	YES	NO
	Reason ______		
♦	What type of delivery?	❑ Vaginal	❑ Cesarean
♦	What was the child's condition at birth?		
	Able to breathe without assistance?	YES	NO
	Heart beating without assistance?	YES	NO
	Required Intensive Care Nursery?	YES	NO
	Transferred to Specialized Neonatal Intensive Care?	YES	NO
♦	Birth Weight ______		
♦	Weeks Gestation (full term is 40 weeks) ______		
♦	Did the baby have any problems while in the hospital?	YES	NO
	If yes, describe the problem ______		
♦	How many days did the baby stay in the hospital? ______		
♦	As an infant, was there any significant illness or injury?	YES	NO
	Describe ______		

Early Childhood History

Approximate age your child was:

Sitting without support ______
Single words developed ______
Walking without support ______
Short sentences developed ______
Crawling ______
Toilet trained ______

Infancy & Early Childhood History

Please check and note dates if your child has had any of the following:

Anemia ______
Allergy ______
Asthma ______
Cancer (type) ______
Chicken Pox ______
Concussion ______
Convulsions ______
Diabetes ______
Eczema ______
Emotional/Behavior Concern ______
Encephalitis ______
Epilepsy ______
Hepatitis (type) ______
Heart Disease ______
Heart Murmur ______
Hernia ______
High Fevers ______
Influenza ______
Lead Poisoning ______
Measles ______
Meningitis ______
Mumps ______
Pneumonia ______
Polio ______
Rheumatic Fever ______
Rubella ______
Scarlet Fever ______
Tonsillitis ______
Tuberculosis ______
Transfusions (blood) ______
Whooping Cough ______

Does the child need prophylactic antibiotic for dental work and/or surgery? ☐ Yes ☐ No

Check if any of the following apply to your child:

_____ Frequent colds
_____ Sore throats
_____ Nosebleeds
_____ Persistent cough
_____ Ear infections
_____ Frequent stomachaches
_____ Wears glasses
_____ Wetting during the day
_____ Frequent headaches
_____ Poor Speech
_____ Speech Therapy
_____ Vision problems
_____ Ear tubes: Date Inserted ______ Date Removed______

Additional health information you want to share: ______

Kutztown Area School District does not discriminate in our educational programs, activities or employment practices based on race, color, national origin, sex, disability, age, religion, ancestry or any other legally protected classification. This policy is in accordance with state and federal laws, including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Sections 503 and 504 of the Rehabilitation Act of 1973 the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990 and the Pennsylvania Human Relations Act. Information relative to special accommodation, grievance procedure, and the designated responsible official for compliance with Title VI, Title IX and Section 504 may be obtained by contacting the school district. EOE