HAMPTON-DUMONT COMMUNITY SCHOOL DISTRICT

Health History

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

Student Name:_____**Date of Birth:**_____**Grade:**_____

HEALTH 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			
Orthopedic							

Allergies: Food_____**Medicine**_____**Environmental**_____

Current Medications (name, dose, times) :_____

Doctor:_____ **Clinic:**_____

Illnesses, operations, or accidents your child has had in past year:_____

Immunizations in past year: _____ **Clinic:**_____

Emotional, social, or other conditions that might affect your child's school performance_____

International travel: My child has been out of the United States during the past year YES_____ **NO**_____ **Name of Country**_____

Insurance Information: Private_____ **Medicaid**_____ **HAWK-I** _____ **No insurance**_____ **Applying for:**_____

Parent Signature:_____ **Date:**_____