Form HPE-h12

School Entrance Health Information Form

Name: _____ Birthdate: Mo. _____ Day _____ Yr. _____
Last First Middle

Sex: ☐Male ☐Female Race: _____ Child's Social Security Number: _____

Parent or Guardian: _____ Work Number: _____
Last First Middle Home Number: _____

Home Address: _____
Street City State Zip

Person to call incase of an emergency if Parent/Guardian is not available:
Name: _____ Phone: _____

Please provide information relative to the general health of your child entering school for the first time and return to the principal within 15 days.

ACUTE or CHRONIC ILLNESSES

☐ Yes ☐No Asthma
☐ Yes ☐No Cerebral Palsy
☐ Yes ☐No Cystic Fibrosis
☐ Yes ☐No Diabetic (Insulin dependent)
☐ Yes ☐No Epilepsy
☐ Yes ☐No Frequent Colds
☐ Yes ☐No Frequent Sore Throat
☐ Yes ☐No Hyperthyroidism
☐ Yes ☐No Hypothyroidism
☐ Yes ☐No Allergies other than related to food/drugs: if yes, describe: _____
_____
☐ Yes ☐No Cancer: if yes, describe: _____
_____
☐ Yes ☐No Heart Disease: if yes, describe: _____
_____

ACCIDENTS

Has your child had any of the following? If yes, describe.

☐ Yes ☐No Burns requiring treatment _____
_____
☐ Yes ☐No Bumps to head requiring treatment _____
_____
☐ Yes ☐No Fractures _____
_____
☐ Yes ☐No Lacerations or cuts requiring stitches or tetanus booster _____
_____
☐ Yes ☐No Near drowning _____
_____
☐ Yes ☐No Poisoning _____
_____
☐ Yes ☐No Serious Fall _____
_____

MEDICATIONS

Is your child using any medicines? If yes, describe.

☐ Yes ☐No Prescription drugs: Identify drugs and condition requiring drugs._____
_____
☐ Yes ☐No Over-the-counter drugs (nonprescription): identify drug and reason for use _____
_____
☐ Yes ☐No Drug Allergies: identify drug and reaction_____
_____

NUTRITION

☐ Yes ☐No Abdominal Pain
☐ Yes ☐No Underweight or Overweight for Age
☐ Yes ☐No Allergies related to foods: identify food and reaction _____
_____
☐ Yes ☐No Problems with elimination (bowel movement and/or urination)_____
_____

OPERATIONS

☐ Yes ☐No Appendectomy
☐ Yes ☐No Hernia
☐ Yes ☐No Tonsillectomy
☐ Yes ☐No Other _____

HANDICAPPING CONDITIONS

☐ Yes ☐No Scoliosis
☐ Yes ☐No Spina Bifida
☐ Yes ☐No Other _____

ORTHOPEDIC DEVICES

☐ Yes ☐No Wheelchair
☐ Yes ☐No Special Shoes
☐ Yes ☐No Crutches
☐ Yes ☐No Braces
☐ Yes ☐No Helmet

HEARING

☐ Yes ☐No Frequent Earaches
☐ Yes ☐No Running Ear
☐ Yes ☐No Hard of Hearing
☐ Yes ☐No Uses Hearing Aids

COMMUNICATION

☐ Yes ☐No Speech Understandable
☐ Yes ☐No Stutters/Stammers
☐ Yes ☐No Lisps

DENTAL

☐ Yes ☐No Cavities
☐ Yes ☐No Cleft Lip or Palate
☐ Yes ☐No Gum Disease
☐ Yes ☐No Lost All of Some of Baby Teeth
☐ Yes ☐No Permanent Teeth Appearing
☐ Yes ☐No Wears Dental Braces

SKIN & HAIR

☐ Yes ☐No Visible Scars
☐ Yes ☐No Hives
☐ Yes ☐No Scabies
☐ Yes ☐No Body Lice
☐ Yes ☐No Head Lice

MENTAL & EMOTIONAL

☐ Yes ☐No Bullies Others
☐ Yes ☐No Cries Often
☐ Yes ☐No Lethargic (slow/lazy)
☐ Yes ☐No Short Attention Span
☐ Yes ☐No Toilet Trained
☐ Yes ☐No Very Sensitive
☐ Yes ☐No Very Shy
☐ Yes ☐No Generally Happy

BLOOD DISORDERS

☐ Yes ☐No Anemia
☐ Yes ☐No Leukemia
☐ Yes ☐No Hemophilia
☐ Yes ☐No Sickle Cell Anemia

HABITS

☐ Yes ☐No Sleeps/Rests Well
☐ Yes ☐No Exercises Daily
☐ Yes ☐No Eats Well
☐ Yes ☐No Bathes Regularly
☐ Yes ☐No Brushes Teeth Daily

VISION

☐ Yes ☐No Wears Glasses
☐ Yes ☐No Rubs Eyes Frequently
☐ Yes ☐No Squints
☐ Yes ☐No Color Blind

Were there any prenatal or birth complications which affected the child? _____
_____
_____

Please indicate any other health condition(s) your child has that is not covered on form _____
_____
_____

Signature: _____ Date: _____
(Signature of Parent/Guardian)