TO BE COMPLETED BY PARENT/GUARDIAN

HAMPTON BOROUGH SCHOOL DISTRICT
ELEMENTARY HEALTH HISTORY

Name_____ Sex_____ Date of Birth_____Grade_____

HEALTH CONDITIONS: check all that apply

____Abnormal spinal curvature
____Anemia
____Arthritis, type _____
____Behavior problems
____Birth/congenital malformations
____Bronchitis
____Cancer, type_____
____Chicken Pox (year)
____Constipation or diarrhea (freq.)
____Cystic Fibrosis
____Diabetes, type_____
____ Ear infections
____ Eczema
____ Hay fever
____ Headaches (freq.)
____ Hearing loss
____ Heart disease
____ Hepatitis
____ Kidney disease
____ Lyme disease (year)
____ Meningitis/encephalitis
____Other _____
____ Nosebleeds (freq.)
____ Seizures
____ Sickle cell disease
____ Sinus infections (freq.)
____ Stool soiling
____ Strep throat
____ Tics/nervous twitches
____ Urinary tract infections
____ Wetting (day/night)

Please comment on any of the above checked items: _____

_____

1. Does your child have any allergies:
   to foods? _____ Yes _____ No
   to drugs? _____ Yes _____ No
   to bee or other insect stings? _____ Yes _____ No

If yes, list allergy to what, type of reaction and the recommended treatment, if any.

_____

_____

_____

2. Does your child have asthma? _____ Yes _____ No

3. Does your child take any medication on a regular basis? _____ Yes _____ No
   Name of medication(s) _____
   Reason(s)_____

4. Has your child ever had a serious illness, injury or operation? Please describe and give dates.

_____

_____

5. Additional comments. _____

_____

_____

Parent/Guardian Signature _____ Date_____

The above information will be reviewed and other forms will be sent to you if additional information is required.

Rev.`05