



STUDENT HEALTH HISTORY

Parent Form

1. **Child's Name:** _____ **Age:** _____ **Date of Birth:** _____

2. **In general, would you say your child's health is**
Excellent____, Very Good____, Good____, Fair____, Poor_____.

3. **Is there any reason you feel that your child cannot fully participate in all school activities? (Y/N)** _____.
If yes, please explain:_____.

4 **Has a physician or healthcare provider ever told you that your child has any of the following? If yes, please indicate the date:**

- | | | |
|-------------------------|------------------------------|-----------------------------|
| ADD/ADHD_____ | Congenital Heart Defect_____ | Bleeding Disorder_____ |
| Asthma_____ | Diabetes_____ | Meningitis_____ |
| Anxiety_____ | Ear Infections_____ | Orthopedic Issues_____ |
| Arthritis_____ | Eczema_____ | Pneumonia_____ |
| Bowel Problems_____ | Cancer_____ | Seizures_____ |
| Bronchitis_____ | Frequent Nosebleeds_____ | Strep Infections_____ |
| Chicken Pox_____ | Gastrointestinal Issues_____ | Urine/Kidney Condition_____ |
| Psychiatric Issues_____ | Other_____ | |

5. **Has a physician or health care provider ever told you that your child has allergies to any of the following? If yes, please list along with any medication that is prescribed:**

- Food_____
- Drugs_____
- Environmental_____
- Bee Stings_____
- Other_____

6. **Operations and Injuries:**

Please list below any operations or injuries with dates and results:_____

7. **Please list all medication your child takes on a regular basis:**

Medication:	Dose:	Time Given:	Reason:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

[If your child should need to have scheduled medication during school hours, we will need a written order from you physician]



9. Does your child have a Primary Care Provider? (Y/N)_____. If yes, please provide:
Name:_____ Date of last physical:_____

10. Has your child needed to see a medical specialist in the past year? If yes, please explain:

11. Does your child have a Dentist? (Y/N) _____. If yes, please provide:
Name:_____ Date of last visit:_____

12. Does your child wear eye glasses? (Y/N) _____.
Has your child ever had a professional eye exam? (Y/N) _____.
If yes, please give date:_____.

13. Has your child ever had any problems with his/her hearing that you are aware of?
(Y/N) _____. If yes, please explain:_____.

14. Does your child have any other health/medical/emotional or social problems that you
feel we should be aware of?

_____.

Please attach a copy of your child's most recent immunizations.

In compliance with the certification of Racial Nondiscrimination for Private School Exempt From Federal Income Tax, Hampstead Academy is required to collect and report data on the ethnicity of its students, staff and faculty members. Please take a moment to check the box below that best reflects your child's ethnic background.

- African American/Black
- Asian/Asian American
- European American (Caucasian)
- Latino/Hispanic American
- Non-US Citizen - Country of Citizenship _____
- Middle Eastern American
- Multiracial American
- Native American
- Pacific Islander American

Parent Signature: _____ **Date:** _____

Please Note: An annual physical exam is required of all children in Pre K-8. (Children who will participate in the upper school sports program are also required to have an annual exam)