KIPP Student Health Background Form 2017-18

In order to help the school nurses best serve your KIPPster, please return this form.

Information will be kept confidentially in the health center.

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| Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [\_\_] Male [\_\_] Female Grade \_\_\_\_\_\_\_ Homeroom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent/guardian name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Who is your child’s regular doctor/clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your child’s last visit with their regular doctor/clinic (month/year)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Don’t know

Who is your child’s regular dentist/clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your child’s last visit with their regular dentist/clinic (month/year)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Don’t know

Does your child have insurance? [ ] Medical assistance [ ] Private insurance [ ] Not currently insured

How many of your children are registered at KIPP this year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Please check the box below if your child has any of the following **medical conditions:** [ ] ADD/ADHD [ ] Diabetes [ ] Genetic disorder[ ] Asthma [ ] Emotional/mental health concerns [ ] Seizure disorder[ ] Bleeding disorder [ ] Heart condition [ ] Skin condition like eczema [ ] History of concussions [ ] Headaches/migraines [ ] Stomach/intestinal problems[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does your child have any **allergies**? If so, please check the box and tell us what kind. [ ] Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Environmental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does your child have a history of anaphylactic reactions or have an Epi-Pen to use? [ ] Yes [ ] No  |
| Does your child take any **medication** on a regular basis? If so, please tell us what:  |
| Do you have any concerns about your child’s.. [ ] Vision [ ] Hearing [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does your child wear glasses? [ ] Yes [ ] No |

If you have any concerns about your child’s physical or emotional health, please feel free to reach out to Nurse Katherine and Nurse Nasreen. They can be reached at 410-396-7844.