KIPP Student Health Background Form, School Year 2026-2027

Please fill out and return this form to help the school take care of your KIPPster. Information will be kept confidentially in the health center.

Student First Name:_____ **Student Last Name**:_____

Sex: □*Male* □*Female* **Birthdate**:_____ **Zip Code**: _____

Grade: _____ **Homeroom** (if known):_____

Parent/Guardian #1:_____ **Phone #**:_____

Parent/Guardian #2:_____ **Phone #**:_____

Emergency Contact:_____ **Phone #**:_____

Who is your child's regular **pediatrician**/clinic? _____

Who is your child's regular **dentist**/clinic? _____

Does your child have **insurance**? □ *Medical assistance* □ *Private insurance* □ *Not currently insured*

Please check the box(es) below if your child has any of the following **medical conditions:**

□ *ADD/ADHD*	□ *Diabetes*	□ *Genetic disorder*	□ *Other*:
□ *Asthma*	□ *Emotional/mental health concerns*	□ *Seizure disorder*	
□ *Bleeding disorder*	□ *Heart condition*	□ *Skin condition*	
□ *History of concussions*	□ *Headaches/migraines*	□ *Stomach/intestinal problems*	

Please explain any **additional information about your child's medical conditions** that the nurses should know:

Does your child have any **allergies**? If so, please check the box and tell us what kind:

□ *Food Allergy*:_____

□ *Environmental Allergy*:_____

□ *Medication Allergy*:_____

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 which medications:

Do you have **concerns** about your child's: □ *Vision* □ *Hearing* □ *Development* □ *Other*:_____

Does your child wear **glasses or contact lenses**? □ *Yes* □ *No*

If you have any concerns about your child's physical or emotional health, please reach out to health center staff. Our nurses can be reached at (410)291-2570.