KENILWORTH PUBLIC SCHOOLS
STUDENT HEALTH INFORMATION

Thank you for completing your child's **Student Health Information Form.**

- The Kenilworth Public Schools Health Services staff makes every effort to keep school staff informed of the specific health problems of our individual students.
- When this information is provided to staff members, it is with the understanding that it is **confidential** and **intended solely for the purpose of giving the staff the necessary tools and information needed to deal with acute/emergency and chronic health problems should they arise during school hours.**
- Your child's medical/health information will be shared **only** with school staff that needs to know to help ensure your child's health and safety.

Student Name _____ DOB _____ Sex _____ Grade _____

General Health Questions	**Yes**	**No**	**Comments if "Yes" & date of occurrence**
Has the student been under a doctor's care in the past 12 months?			
Has the student been hospitalized in the last 12 months?			
Has the student ever had any surgeries?			
Does the student have any missing organs? (eye, kidney, testicle, etc.)			
Has the student ever had chest pain during or after exercise?			
Does the student have trouble with breathing or coughing during or after activity?			
Condition	**Yes**	**No**	**Comments if "Yes" & date of occurrence**
Anemia			
Allergies (**food, insects, medications, latex**)			
Allergies/Hay fever (seasonal)			
Asthma **Use of Inhaler?**			
Attention-Deficit/Hyperactivity Disorder			
Behavioral problems			
Bladder problems			
Bowel problems			
Bronchitis			
Cancer			
Cerebral Palsy			
Chicken Pox			
Cystic Fibrosis			
Dental Problems			
Developmental problems			
Diabetes			
Ear Infections (frequent)			
Eczema			
Glasses or contact lenses			
Head or Spinal injury			
Headaches (frequent)			
Hearing Aide(s)			
Hearing problems or Deafness			
Heart problems			
Hemophilia			
Hepatitis			
High Blood Pressure			

Condition	Yes	No	Comments if "Yes" & date of occurrence
Hydrocephalus			
Immune disorder			
Kidney problems			
Lyme Disease			
Meningitis			
Migraines			
Mononucleosis			
Muscular Dystrophy			
Muscle problems			
Orthopedic problems			
Pneumonia			
Seizures			
Sickle Cell Disease			
Skin problems			
Skull Fracture			
Speech problems			
Stomach problems			
Strept throat (frequent)			
Tuberculosis			
Vision problems			
Other			

List all prescription and over-the-counter **medications** your child takes regularly:
Describe any other important health-related information about your child:

Student's Pediatrician or Primary Care Provider:	Medical Specialists or Specialty Clinics caring for this student:
Has the student ever seen a Dentist? Yes No (circle one)	Name of Dentist:

For Parents/Legal Guardians of Students
The information on this form is current and correct to the best of my knowledge. I understand that if the medical status of my child changes in any significant way, **I will notify his/her school nurse of the change immediately**. I also understand that my child's health/medical information may be shared with other school staff members in order to ensure my child's health and safety while at school.

By signing below, I am agreeing to the above statements.	
Signature of Parent or Legal Guardian:	**Date:**

For Nursing Use Only:

Action Plan Received ☐ IHP ☐ Emergency Response Plan ☐ 504 Plan ☐ Medication Forms ☐