KURN HATTIN
A Home for Children
FOUNDED IN 1894

HEALTH FORM

NEW ENGLAND
KURN HATTIN HOMES
P.O. BOX 127
WESTMINSTER, VT 05158
www.kurnhattin.org

TEL: (802) 722-3336
FAX: (802) 722-3174

Child's Name _____ DOB _____

The information on this form is confidential and strictly for the use of Health Services in providing necessary health care while your child is a student at New England Kurn Hattin Homes. It will not be released to anyone without your knowledge and consent.

STUDENT'S HISTORY – ALL QUESTIONS MUST BE ANSWERED. Comment on all "yes" answers on additional sheet.

DOES YOUR CHILD HAVE OR HAVE THEY EVER HAD:	YES	NO
Measles		
German Measles		
Mumps		
Chicken Pox		
Gum or Tooth Trouble		
Sinusitus		
Eye Trouble		
Ear, Nose, Throat Trouble		
Surgery		
Appendectomy		
Tonsillectomy		
Hernia Repair		
Other (What?)		
Recurrent Headache		
Recurrent Colds		
Head Injury with Unconsciousness		
Hay Fever		
Asthma – Date of Last Attack ( )		
Tuberculosis		
Shortness of Breath		
Allergy		
Penicillin		
Sulfa Drugs		
Other Medications (Which?)		
BEES, HORNETS, WASPS		
Foods (Which?)		
Other (What?)		
Insomnia (Trouble Sleeping)		
Frequent Anxiety (Worries A Lot)		
Frequent Depression		
Pain/Pressure in Chest		

	YES	NO
Chronic Cough		
Palpitations (Heart)		
High or Low Blood Pressure		
Rheumatic Fever or Heart Murmur		
Disease or Injury of Joints		
"Trick" Knee, Shoulder, etc.		
Back Problems		
Tumor, Cancer, Cyst		
Stomach or Intestinal Trouble		
Jaundice		
Gallbladder Trouble or Gallstones		
Recurrent Diarrhea		
Rupture, Hernia		
Recent Gain or Loss of Weight		
Dizziness or Fainting		
Weakness, Paralysis		
Venereal Disease (Herpes, Warts, Other)		
Albumin/Sugar in Urine or Diabetes		
Kidney Disease		
Seizure Disorder		
Bed-wetting (Enuresis)		
Soiling (Encopresis)		
Motion Sickness		
Speech Problems		
GIRLS ONLY		
Irregular Periods		
Severe Cramps		
Excessive Flow		
Age of First Period ( )		
Birth Control Method/Medication		
Permission for Gyn (Pelvic) Exam		

over →

Does your child have a history of . . . □ smoking, □ drinking alcohol, □ using recreational drugs, □ being sexually active, □ harming him or herself?
Does your child have any . . . □ tattoos or □ body piercings?

Has your child . . .	Yes	No
had his/her activity restricted during the past five years? (Give reasons and durations)		
received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (Give details)		
had any illness or injury or been hospitalized other than already noted? (Give details)		
consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (other than routine checkups)		
ever been immunized against tuberculosis with BCG vaccine?		
been tested for AIDS/HIV?		
been tested for sickle cell anemia?		
Do you have any concerns about your child's eating habits?		

IMMUNIZATION HISTORY: This information is available from your child's physician or school.

Record Month, Day and Year.	1	2	3	4	5
DTP (Diphtheria, Tetanus, Pertussis)					
DT (Pediatric Diphtheria, Tetanus)					
Td (Adult Tetanus, Diphtheria)					
Tetanus – Note Type					
Polio – Note Type					
Hep-B (recommended)				Physician Diagnosed	
Measles			Measles Disease _____/_____ Month Year		
Rubella					
Mumps			Exempt: Medical _____		
MMR (Mumps, Measles, Rubella)			Religious _____		
PPD (mandatory prior to admission)			Moral _____		
HIB (note type)			Attach Signed Form		

ORAL HEALTH HISTORY

Date of last dental exam: _____ Dentist: _____
Address: _____ Phone: _____
Orthodontics (braces)? □Yes □No Orthodontist/specialist: _____
Address _____

STUDENT'S FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

_____ _____
Signature of Parent/Guardian Date