EASTON PUBLIC SCHOOLS
EASTON, MA

SUPPLEMENTAL HEALTH REPORT – KINDERGARTEN

Please provide the following information on your child. This information is helpful to the School Nurse and Principal in identifying potential problems and in monitoring your child's health at school.

Child's Information

Child's Name: ____
First Middle Last

Home Address: Street______________________________________ Apt. __________

City__________________________ State__________Zip______________

Home Telephone:____________________ Cell:_____________________________

Mother's Information

Mother's Name: ____
First Middle Last

Address (if different than child's):______________________________________

Date of Birth:____________ Education (Highest Grade/Degree Completed):____________________

Occupation:____________________ Work Telephone:________________ Ext.____________

Father's Information

Father's Name:____
First Middle Last

Address (if different than child's):______________________________________

Date of Birth:____________ Education (Highest Grade/Degree Completed):____________________

Occupation:____________________ Work Telephone:________________ Ext.____________

Other Family Information

Health Insurance Name and Policy Number:______________________________________

Names and ages of other children in the family:__________________________________

Other people living in the household:____

What language is spoken at home? ____

Today's Date:____________________ Parent/Guardian Signature:__________________________

[Type text]

Medical History

Any problems during pregnancy?_______________ If yes, what?____

Child's birth weight: ____lbs.____oz. Was your child more than 3 weeks premature?________________________

Any health concerns at birth?____

Has your child been hospitalized (in-patient or out-patient) since birth?_________

If yes, please explain:____

____

Does your child have allergies?

☐ No ☐ Yes If yes, please describe:____

____

What medication does your child take? ____

Does your child see a doctor for any of the following conditions: epilepsy, diabetes, asthma, heart disease, kidney disease, orthopedic problem or any other health problem?

☐No ☐ Yes If yes, please describe:____

____

Has your child had any accidents or injuries (falls, sprains, broken bones, stitches, and poisonings)?

☐No ☐ Yes If yes, please describe:____

____

Please describe any other health concerns:____

____

Would you like to talk to your School Nurse about your child's health or concerns you may have about your child?

☐No ☐Yes If yes, please call the School Nurse at the school your child will be attending. You may also talk to the Nurse about health insurance that may be available to you.

Date of Child's most recent physical examination: ____

Child's Physician:____

Physician's Telephone Number:____

Address:____

Today's Date:_________________________ Parent/Guardian Signature:______________________________________

[Type text]