



KURN HATTIN HOME AND  
 SCHOOL FOR CHILDREN  
 PO BOX 127  
 WESTMINSTER, VT 05158  
 www.kurnhattin.org

## HEALTH FORM

TEL: (802) 721-6956  
 FAX: (802) 722-6911

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		
MRSA		
Gum or Tooth Trouble		
Sinusitis		
Eye Trouble		
Ear, Nose, Throat Trouble		
Surgery		
Appendectomy		
Tonsillectomy		
Hernia Repair		
Other (What?)		
Recurrent Headache		
Recurrent Colds		
Head Injury with Unconsciousness		
Environmental Allergies		
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		

	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		
<b>GIRLS ONLY</b>		
Irregular Periods		
Severe Cramps		
Excessive Flow		
Age of First Period (            )		
Birth Control Method/Medication		

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 Exempt: Medical ____ Religious ____ Moral ____ Attach Signed Form
Rubella					
Mumps					
MMR (Mumps, Measles, Rubella)					
PPD (mandatory prior to admission)					
HIB (note type)					

**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



**THIS SHEET IS TO BE COMPLETED AND SIGNED BY YOUR PHYSICIAN**

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[www.kurnhattin.org](http://www.kurnhattin.org)  
TEL: (802) 722-3336  
FAX: (802) 722-3174

**Report of Health Evaluation**

Send Evaluation to: Kurn Hattin Home and  
School for Children  
Admissions Department  
PO Box 127  
Westminster, VT 05158  
(802) 721-6913  
Fax (802) 722-3174  
[www.kurnhattin.org](http://www.kurnhattin.org)

This examination must have been done within the last six months.  
All students are required to have a complete physical every two years.

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Urinalysis  
Sugar \_\_\_\_\_  
Protein \_\_\_\_\_  
Blood \_\_\_\_\_  
Hemoglobin or Hematocrit \_\_\_\_\_  
Cholesterol \_\_\_\_\_  
Sickle Cell \_\_\_\_\_  
(If Indicated)

Blood Pressure \_\_\_\_\_  
Height \_\_\_\_\_ inches  
Weight \_\_\_\_\_ lbs.  
PPD \_\_\_\_\_  
Vision: Far \_\_\_\_\_  
Near \_\_\_\_\_  
Glasses Yes \_\_\_ No \_\_\_  
Last Eye Exam: \_\_\_\_\_  
Hearing L: \_\_\_\_\_  
R: \_\_\_\_\_

\*Are there abnormalities of the following systems? Describe fully. Use additional sheet if necessary.

	Yes	No
Head, nose, throat		
Eyes/vision		
Hearing/ears		
Respiratory		
Cardiovascular		
Hernia		
Genitourinary		
Musculoskeletal		
Metabolic/endocrine		
Neuropsychiatric		
Skin		
Any other condition		

Does the child have any allergies? Yes \_\_\_ No \_\_\_ If yes, to what?  
Is this student capable of physical activity and participation in a competitive athletic program? \_\_\_\_\_  
Any Restrictions? \_\_\_\_\_  
Medications/Diagnosis: \_\_\_\_\_  
Are any medications currently being used? \_\_\_\_\_  
Explain \_\_\_\_\_  
Please record any immunizations given on date of exam: \_\_\_\_\_  
Examining Physician \_\_\_\_\_ Date \_\_\_\_\_ Date of Exam \_\_\_\_\_  
Address \_\_\_\_\_ Signature \_\_\_\_\_  
Phone \_\_\_\_\_