

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
Address (Number, Street, City, State, Zip)			Phone No.	
Parent/Guardian Names				
Where do you usually take your child for routine medical care?			Phone No.	
Name:		Address:		
When was the last time your child had a physical exam? Month		Year		
Where do you usually take your child for dental care?			Phone No.	
Name:		Address:		
ASSESSMENT OF STUDENT HEALTH				
To the best of your knowledge has your child any problem with the following? Please check				
	Yes	No	Comments	
Allergies (Food, Insects, Drugs, Latex)				
Allergies (Seasonal)				
Asthma or Breathing Problems				
Behavior or Emotional Problems				
Birth Defects				
Bleeding Problems				
Cerebral Palsy				
Dental				
Diabetes				
Ear Problems or Deafness				
Eye or Vision Problems				
Head Injury				
Heart Problems				
Hospitalization (When, Where)				
Lead Poisoning/Exposure				
Learning problems/disabilities				
Limits on Physical Activity				
Meningitis				
Prematurity				
Problem with Bladder				
Problem with Bowels				
Problem with Coughing				
Seizures				
Serious Allergic Reactions				
Sickle Cell Disease				
Speech Problems				
Surgery				
Other				
Does your child take any medication?				
No Yes Name(s) of Medications: _____				
Is your child on any special treatments? (nebulizer, epi-pen, etc.)				
No Yes Treatment _____				
Does your child require any special procedures? (catheterization, etc.)				
No Yes				
Parent/Guardian Signature _____			Date: _____	