PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Full Name	Birthdate (mo,day,yr)	Sex M/F	Name of School	Grade

Full Address: (please write on above line) Phone No#

Parent/Guardian Names:

Where do you usually take your child for routine medical care? Address: Phone#

When was the last time your child had a physical exam? Month: Year:

Where do you usually take your child for dental care? Address: Phone#

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge has your child any problems 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 and Vision Problems			
Head Injury			
Heart Problems			
Hospitalizations (when, where)			
Lead Poisoning/Exposure			

Learning Problems/Disabilities			
Limits on Physical Activities			
Meningitis			
Prematurity			
Problems with Bladder			
Problems with Bowels			
Problem with Coughing			
Seizures			
Serious Allergic Reactions			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medications?

No **Yes** **Name(s)**____

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**_____________________________