



ASSESSMENT OF STUDENT HEALTH

Student's Name _____ Birth Date _____ Grade _____
Address _____ Home Phone _____
City _____ Zip _____
Parent/Guardian Name _____ Signature _____

1. Does your child have a condition which may require emergency action while at school?
(e.g., seizure, bee sting allergy, bleeding problem, diabetes, heart problem) YES NO
Describe condition: _____
Describe emergency action: _____
2. List allergies: **Food** _____ **Drug** _____ **Other** _____
Describe allergic reaction: _____
Indicate treatment for reaction: _____
3. Has your child had or does s/he currently have any significant illnesses or injuries? YES NO
Please describe: _____
4. Has your child had any surgical operations? YES NO
5. Will your child be on medication during the school year? YES NO
If yes, will they will be administered at school? YES NO
Your physician must list each medication and dosage on the Medicine Administration form. If any changes occur, please let us know immediately.
6. Does your child have any vision problems? YES NO
7. Does your child have any hearing problems? YES NO
8. Does your child have any dental problems? YES NO
9. Is there any reason your child should not participate in any sport? YES NO
10. Does your child have any other health or psychosocial issues? YES NO

Please explain any YES answers or pertinent, additional information: _____

The health information provided on this form will be available only to those health and school personnel who have legitimate educational interest in your child.

PHYSICIAN HEALTH EVALUTION

Must be filled out by a physician

Physician's Note: _____

PHYSICAL EXAM

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Physical Restriction – Please specify _____

Medications – Please complete the medicine administration form

Physician's Name (please print) _____

Phone # _____ Physician's Signature _____