HEALTH ASSESSMENT

-To be completed by Parent / Guardian -

Student Name (Last, First, Middle)	DOB (MM/DD/YY)	School	Grade

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have any problems, which may affect his/her learning in school, cause you any concern and/or may be important for school staff to know?_____

_____

Please check "YES" or "NO" with an 'X' for each of the following questions:

QUESTION:	**YES**	**NO**
1. Do you have any concerns about your child's general health (eating and sleeping habits, bowel or bladder, posture, teeth, skin, menstruation, weight, etc.) ?	____	____
2. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes, wears glasses or contact lenses) ?	____	____
3. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, draining ear, use a hearing aid) ?	____	____
4. Does your child have any speech problems (difficulty having speech understood, stammering, delayed speech development) ?	____	____
5. Does your child have any allergies (food, insects, drugs, pollen, etc.) ?	____	____
6. Does your child have any other specific sickness or problem, which might in your opinion affect school performance or program?	____	____
a. Has your child received any medical or other evaluation, the findings of which could help school personnel in meeting his/her health or educational needs?	____	____
b. Does this problem require any special health care in the school?		
c. Does your child take any medication?	____	____
7. Do you have any concerns about your child's developmental behavior or emotional well-being of which the school should be made aware of ?	____	____
8. Has your child had any serious illness, accident or surgery in the past 12 months?	____	____

REMARKS: PLEASE EXPLAIN ANY "YES" ANSWERS

_____

If you would like to discuss your child's health with the school or school health personnel, please check title with an 'X':

Nurse assigned to school ____ Teacher ____ Counselor ____ Principal ____

I give my permission for confidential and discreet use of the health evaluation completed by the physician to meet my child's health and educational needs in school. I give my consent for administration of Benadryl or Adrenalin in the event of an allergic reaction.

Please check one: Yes ___No ____

_____ _____

Parent / Guardian Signature **Date**