HEALTH ASSESSMENT RECORD

School Year: _______-_______

To Parent or Guardian:
The purpose of this form is to provide the school nurse with additional information regarding you child's health needs. The school nurse may contact you for further information. The information requested is essential for the school nurse to meet the health needs of your child.

This information will be kept confidential.

PLEASE complete both sides of this form (Return to the School Nurse)

Name of Student (Last, First Middle)	Birth Date	Sex	School, Grade

Address (Street)

Name of Parent/Guardian (Last, First, Middle)	Phone number to reach during school hours

Name of 2nd Parent/Guardian (Last, First, Middle)	Phone number to reach during school hours

Before School Transportation
☐ Bus Rider Bus Route: ☐ Car Rider ☐ Special Needs Bus ☐ After School Program

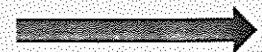
After School Transportation
☐ Bus Rider Bus Route: ☐ Car Rider ☐ Special Needs Bus ☐ After School Program

Part I – Health Information

☐Check here if your child does not regularly visit a specific place for health care

Place your child receives health care:	Place your child receives dental health care:
Physician's Name: ______________________	Physician's Name: ______________________
Phone: ______________________	Phone: ______________________

Please Complete Back of Form (Signature Required)



HEALTH ASSESSMENT RECORD

School Year: _______-_______

Part II – Medical History

Name of Student

☒ YES ☐ NO	**Known Health Problems** **If NO**, go directly to the bottom of the page and provide parent/guardian signature **If YES**, and diagnosed by a physician, answer each question below.
☐ YES ☐ NO ☐ YES ☐ NO	**Attention Deficit Disorder (ADD)** **Attention Deficit Hyperactivity Disorder (ADHD)** **Requires medication** ☐ At School ☐ At Home
☐ YES ☐ NO	**Allergies:** ☐ Hives/Rash ☐ Medications ☐ **Food** ____________ ☐ Breathing Difficulty ☐ Epi-pen ☐ **Insects** ____________ ☐ Other: ☐ **Environmental** ____________ ☐ **Medications** ____________
☐ YES ☐ NO	**Asthma** ☐ **Uses an inhaler at school** ☐ **Uses an inhaler at home**
☐ YES ☒ NO ☐ YES ☐ NO	**Blood/Bleeding Problems:** ☐ **Hemophilia** ☐ **Von Willebrand's** ☐ **Other** ☐ **Requires medication** ***Please explain:*** **Frequent Nose Bleeds:** ***Please explain***
☐ YES ☐ NO	**Cerebral Palsy:** ***Please explain***
☐ YES ☐ NO	**Diabetes** ☐ **Type 1 Diabetes** ☐ **Monitors Blood Sugars at School** ☐ **Requires Insulin at School** ☐ **Insulin pump** ☐ **Glucagon order** ☐ **Type 2 Diabetes** ☐ **Managed with diet** ☐ **Oral medication**
☐ YES ☐ NO	**Emotional/Behavioral/Psychological:** ***Please explain:***
☐ YES ☐ NO	**Headaches:** ***Please explain:***
☐ YES ☐ NO	**Hearing Problems:** ☐ **Right ear** ☐ **Left ear** ☐ **Both ears** ☐ **Hearing loss** ☐ **Hearing aid** ☐ **Tubes** ☐ **Cochlear Implant**
☐ YES ☐ NO	**Heart Condition:** ☐ **Activity restrictions:** ☐ **Medications taken at home:** ***Please explain:***
☐ YES ☐ NO	**Scoliosis:** ☐ **No Treatment** ☐ **Wears Brace** ☐ **Surgery** ☐ **Family History**
☐ YES ☐ NO	**Seizures/Convulsions: Type of seizure:**____________ ***Medications:*** ☐ **Diastal** ☐ **Klonopin** ☐ **Versed** ☐ **Medication taken at home** ☐ **Other**________ ***Please explain:***
☐ YES ☐ NO	**Sickle Cell:** ☐ **Anemia** ☐ **Trait**
☐ YES ☐ NO	**Special Diet:** ***Please explain:***
☐ YES ☐ NO	**Vision Problems:** ☐ **Wears glasses** ☐ **Wears contacts** ☐ **Other**
☐ YES ☐ NO	**Other Medical Condition:** ***Please include any*** **medications taken at home only**

Required Signatures

Parent(s) or Guardian(s) Signature(s): ______________________________ Date:__________

School Nurse Signature: ______________________________ Date:__________