Student Health Assessment

Student's Name _____

Does your student have any known allergies or sensitivities to the following? (Check all that apply)			
	No	Yes	If **Yes** Please List
Medications			
Foods (Milk?)			
Other			

Family Physician: _____

Phone:_____

Dentist: _____

Phone:_____

Preferred Hospital:_____

Please describe any injuries your child has experienced:

_____

_____

Please describe all serious illnesses experienced by your child, including measles, mumps, etc.:

Chronic medical conditions?	N	Y
Asthma		
Diabetes		
Seizures		
Heart Problems		
Hearing Impairment		
Visual Impairment		
Developmental Delays		
Physical Impairment		
Behavior or Emotional Problems		

_____

List any regular medications your child takes: _____

_____

List any additional health information or special instructions: _____

_____

Parent / Guardian Signature _____ Date _____

This form must be completed for each student enrolled and must be reviewed annually by the parent / guardian, and any changes noted:

Reviewed and Up to Date _____ Parent / Guardian Signature _____

Reviewed and Up to Date _____ Parent / Guardian Signature _____

Please Note: Some classrooms have pets, including, but not limited to fish, rats, and dogs.