



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
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Address (Street)

Name of Parent/Guardian (Last, First, Middle)	Phone number to reach during school hours
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Name of 2 nd Parent/Guardian (Last, First, Middle)	Phone number to reach during school hours
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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 <u>dental</u> care:
Physician’s Name: _____	Dentist Name: _____
Phone: _____	Phone: _____

Please Complete Back of Form (Signature Required) 

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Part II – Medical History

Name of Student			
<input type="checkbox"/> YES <input type="checkbox"/> 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.		
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	Attention Deficit Disorder (ADD) Attention Deficit Hyperactivity Disorder (ADHD) Requires medication <input type="checkbox"/> At School <input type="checkbox"/> At Home		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergies: <input type="checkbox"/> Food _____ <input type="checkbox"/> Insects _____ <input type="checkbox"/> Environmental _____ <input type="checkbox"/> Medications _____	<input type="checkbox"/> Hives/Rash <input type="checkbox"/> Breathing Difficulty <input type="checkbox"/> Other:	<input type="checkbox"/> Medications <input type="checkbox"/> Epi-pen
<input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma <input type="checkbox"/> Uses an inhaler at school <input type="checkbox"/> Uses an inhaler at home		
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	Blood/Bleeding Problems: <input type="checkbox"/> Hemophilia <input type="checkbox"/> Von Willebrand's <input type="checkbox"/> Other <input type="checkbox"/> Requires medication : <i>Please explain:</i> Frequent Nose Bleeds: <i>Please explain:</i>		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer/Leukemia: <i>Please explain:</i>		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cerebral Palsy: <i>Please explain:</i>		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cystic Fibrosis: <i>Please explain:</i>		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Dental Problems: <i>Please explain:</i>		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Monitors Blood Sugars at School	<input type="checkbox"/> Managed with diet	<input type="checkbox"/> Requires Insulin at School <input type="checkbox"/> Insulin pump <input type="checkbox"/> Glucagon order <input type="checkbox"/> Oral medication
<input type="checkbox"/> YES <input type="checkbox"/> NO	Emotional/Behavioral/Psychological: <i>Please explain:</i>		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Gastrointestinal/Stomach Problems: <i>Please explain:</i>		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Genetic/ Rare Disorders: <i>Please explain:</i>		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches: <i>Please explain:</i>		

<input type="checkbox"/> YES <input type="checkbox"/> NO	Hearing Problems: <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> Both ears <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hearing aid <input type="checkbox"/> Tubes <input type="checkbox"/> Cochlear Implant
<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Condition: <input type="checkbox"/> Activity restrictions: <input type="checkbox"/> Medications taken at home: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hypertension (High Blood Pressure): <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Juvenile Arthritis/ Bone-Joint Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney/Bladder/Urinary Problems: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Scoliosis: <input type="checkbox"/> No Treatment <input type="checkbox"/> Wears Brace <input type="checkbox"/> Surgery <input type="checkbox"/> Family History
<input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures/Convulsions: Type of seizure: _____ Medications: <input type="checkbox"/> Diastal <input type="checkbox"/> Klonopin <input type="checkbox"/> Versed <input type="checkbox"/> Medication taken at home <input type="checkbox"/> Other _____ <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Sickle Cell: <input type="checkbox"/> Anemia <input type="checkbox"/> Trait
<input type="checkbox"/> YES <input type="checkbox"/> NO	Spina Bifida:
<input type="checkbox"/> YES <input type="checkbox"/> NO	Special Diet: <i>Please explain:</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Vision Problems: <input type="checkbox"/> Wears glasses <input type="checkbox"/> Wears contacts <input type="checkbox"/> Other
<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Medical Condition: <i>Please include <u>any</u> medications taken at home only</i>

Required Signatures

Parent(s) or Guardian(s) Signature(s): _____ Date: _____

School Nurse Signature: _____ Date: _____