_____ New Student ____Returning Student

Health Assessment Form 2017-18

Student Name ____ Gender M ___ F___

Date of Birth _________________ Grade/Class _____________________________

If your child has any allergies – PLEASE list, the type and severity of the reaction. For food allergies please list if it is through absorption, ingestion or inhalation. A Food Allergy Emergency Plan is required to be on file for all food allergies diagnosed by a physician.

To the best of your knowledge, does your child have any problems in the following areas? **Please mark "Yes" or "No" for each of the following**:
DO NOT LEAVE ANY "YES" OR "NO" BOX BLANK

	Yes	**No**	**Comments/Details**
Allergies - Drugs			
Allergies – Foods			
Allergies - Insects			
Allergies - other			
Epi Pen required for any allergies			
Asthma			
Diabetes			
Meningitis			
Seizures			
Cerebral Palsy			
Sickle Cell Disease			
Heart Problems			
Bleeding Problems			
Kidney/Bladder Problems			
Bowel Problems			
Ear or Hearing Problems			
Eye or Visions Problems			
Speech Problems			
Behavior Emotional Problems			
Prematurity			
Birth Defects			
Hospitalization – when, why			
Surgery – when, why			
Limits on Activity			
Medication - everyday			
Medication – as needed			
Other Special Needs			

____ ____________

Signature, Parent/Guardian Date