Student Health Assessment

Student ____ Date of Birth _____________

Grade _________ Year __________ Homeroom __________________________________

PLEASE COMPLETE THE FOLLOWING AND RETURN TO SCHOOL NURSE

DOES STUDENT HAVE:

	YES	NO
ASTHMA/BREATHING PROBLEMS		
ALLERGIES TO FOOD, MEDICATION, OR INSECTS		
DIABETES		
HEART PROBLEMS		
EPILEPSY/SEIZURES		

LIST ANY CURRENT MEDICATIONS OR OTHER HEALTH CONCERNS (please explain) _______________

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IF YES TO ABOVE, IS YOUR CHILD CURRENTLY UNDER A PHYSICIAN'S CARE? ☐ YES ☐ NO

NAME/PHONE NUMBER OF PHYSICIAN ____

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IF YOUR CHILD IS ON MEDICINE THAT MUST BE GIVEN AT SCHOOL, YOU MUST CONTACT THE SCHOOL NURSE TO OBTAIN PROPER FORMS. NO MEDICATION WILL BE GIVEN IF THE PROPER PAPERWORK IS NOT COMPLETED.

I GIVE PERSMISSION FOR MY CHILD TO BE SCREENED FOR VISION, HEARING, SPEECH, SCOLIOSIS, CONTAGIONS AND PARASITES BY TRAINED SCHOOL PERSONNEL.

IN ACCORDANCE WITH KENTUCKY STATE LAW EVERY STUDENT MUST HAVE A CURRENT IMMUNIZATION CERTIFICATE TO BE LEGALLY ENROLLED IN SCHOOL.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. ANY CHANGES IN HEALTH CONDITION WILL BE REPORTED IMMEDIATELY TO THE SCHOOL HEALTH TEAM.

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PARENT/GUARDIAN SIGNATURE DATE

Emergency /Daytime Phone Number ___________________________________