

This form is due
back on or before
August 1st!

School of St. Ann
Health Assessment Form
School Year: 2007-2008

Student's Name: _____ Grade/Room #: _____ Age: _____ Birthdate: _____

HEALTH CONDITIONS *(Please answer 1-15 by circling YES or NO)* 

1. Does your child have any medical conditions/injuries currently under treatment? Yes No Explain: _____

2. Any physical limitations? Yes No Please explain: _____

3. Asthma? Yes No, Medication? Yes No, Allergy Shots? Yes No, Breathing Treatments? Yes No, Inhaler for school? Yes No
Please list any medications your child takes at home or school for Asthma: _____

4. Allergies? Yes No, Circle those that apply: food / drugs / seasonal/hay fever / insects/animals Have an Epi Pen? Yes No
Please list what your child is allergic to: _____

5. Does your child have Diabetes? Yes No Age at diagnosis? _____ Treatment regime: _____

6. A history of speech or hearing problems? Yes No, Please Explain: _____

7. Frequent Earaches? Yes No, Medications? Yes No, Tubes? Yes No

8. Frequent Headaches? Yes No, Migraine Headaches? Yes No What medications are used to treat? _____

9. Frequent Nosebleeds? Yes No What is treatment? _____

10. Frequent Sore Throat? Yes No Strep Throat more than 4 times last year? Yes No Has had tonsils/adenoids out? Yes No

11. Frequent Stomach Aches? Yes No, Medications? Yes No, List meds for stomachache _____

12. Does your child wear glasses? Yes No, Contacts? Yes No, Farsighted? Yes No, Nearsighted? Yes No, Lazy Eye? Yes No

13. Does your child have epilepsy or seizures? Yes No, Medication for seizures? Yes No Medication _____

14. Does your child take any other daily medications? Yes No, Will medications be taken at school? Yes No

a. Explain reason for medication: _____

b. Medication/Dosage: _____

c. Time(s) of day given: _____

15. Does my child have Health Insurance? ___ Yes ___ No:

16. School Attended Last Year: _____ St. Ann _____ Other _____

17. Are there any factors that the school nurse, counselor or teacher should know of which might affect your child's school experience?:

18. I know of no health reason(s), other than the information indicated on this form, why my child should not participate in any school activity. I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. If transportation by ambulance is required, your child will be taken to the closest hospital.

19. Physician: _____ Phone: (_____) _____

20. Dentist: _____ Phone: (_____) _____

 21. _____

Date

Signature of Parent/Guardian

St. Ann Annual Health Assessment 2007-08