Parent Health Assessment

School Year: 2023-2024

HEALTH CONDITIONS: (Please mark yes or no below)

Student's Name: _____ **Grade** _____ **Age:** ____ **Birthdate:** _____ ◯ **Female** ◯ **Male**

1. **Does your child have any medical conditions/injuries currently under treatment?**
   ◯ **Yes** ◯ **No**

Explain: _____

2. **ADHD Medication**
   ◯ **Yes** ◯ **No** **Name/dose of Medication and time given:** _____
3. **ADD Medications?**
   ◯ **Yes** ◯ **No** **Name/dose of Medication and time given:** _____
4. **Asthma?**
   ◯ **Yes** ◯ **No**
5. **Inhaler at school?** **Name of Inhaler:** _____
   ◯ **Yes** ◯ **No**
6. **Breathing Treatments?** **Name of Medication:** _____
   ◯ **Yes** ◯ **No**
7. **Allergy Shots?**
   ◯ **Yes** ◯ **No**
8. **Allergies? Epi Pen at school?** ◯ **Yes** ◯ **No**
   ◯ **Food** ◯ **Medicine** ◯ **Insects** ◯ **Animals** ◯ **Seasonal** ◯ **Airborne** ◯ **Ingestion** ◯ **Touching of product**

List food, animal and drug allergies: _____

9. **Does your child have Diabetes?**
   ◯ **Yes** ◯ **No** **If YES: Age at diagnosis?** _____ **Treatment regime:** _____
10. **A history of speech or hearing problems?**
    ◯ **Yes** ◯ **No** **Hearing Aid?** ◯ **Yes** ◯ **No** **Which ear?** ◯ **Right** ◯ **Left** ◯ **Both**
11. **Receiving speech therapy at:** _____

    ◯ **Yes** ◯ **No**
12. **Tubes in Ears?**
    ◯ **Yes** ◯ **No**
13. **Frequent Headaches?**
    ◯ **Yes** ◯ **No**
14. **Migraine Headaches?**
    ◯ **Yes** ◯ **No**
15. **Does my child have any learning disabilities? Please List:** _____
    ◯ **Yes** ◯ **No** **Does my child have an IEP or 504 Plan? IEP:** ◯ **Yes** **504:** ◯ **Yes**
16. **Does your child wear glasses?**
    ◯ **Yes** ◯ **No**

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17. **Contacts?**
    ◯ **Yes** ◯ **No**
18. **Farsighted?**
    ◯ **Yes** ◯ **No**
19. **Nearsighted?**
    ◯ **Yes** ◯ **No**
20. **Lazy Eye?**
    ◯ **Yes** ◯ **No**
21. **Does your child have epilepsy or seizures?** **Name of medication:** _____
    ◯ **Yes** ◯ **No**
22. **Celiac Disease?** ◯ **Yes** ◯ **No** **Gluten Free Diet?** ◯ **Yes** ◯ **No**
23. **Any physical limitations? Please explain:** _____
24. **Does my child have Health Insurance?** ◯ **Yes** ◯ **No**
25. **School Attended Last Year:** ◯ **St. Ann** ◯ **Other**
26. **Are there any factors that the school nurse, counselor or teacher should know of which might affect your child's school experience?** _____
    _____
27. **I know of no health reason(s), other than the information indicated on this form, why my child should not participate in any school activities. I authorize school personnel to obtain emergency medical care for my child in the event I can't be reached. If transportation by ambulance is required, your child will be taken to the closest hospital.**
28. **Physician:** _____ **Phone:** _____
29. **Dentist:** _____ **Phone:** _____
    _____

_____ _____
Date/ **Signature of parent/guardian**