STUDENT HEALTH ASSESSMENT
Confidential Information

School: _____ School Year: 20___ - 20___

The following is a brief health form that must be returned to your child's teacher **as soon as possible.** This information will be reviewed by the school nurse and used to meet your child's health needs at school.

Student's Name: _____ Date of Birth: _____

(First, Middle Initial, Last)

Gender: ___ Male ___ Female **Grade: _____ Teacher: _____**

How does student get to and from school (check all that apply)**:** ___Car Rider ___Walk ___ Bus #: _____

If Military, is your child required to go to Blanchfield Army Community Hospital (BACH)? ___YES ___NO

Please list student's current medications: _____

You may treat my child with the following first aid medications: Bacitracin, Bactine, Wound Cleanser, Sting Wipes, Burn Spray or Gel, Hydrocortisone Cream, Callergy and Vaseline _____YES _____NO **SIGNATURE:** _____

Please check below any conditions your child has:		**___ MY CHILD HAS NO HEALTH CONDITIONS**	
___ADD/ADHD ***see below***	___Diabetes ***see below***	___Migraine Headaches	___Juvenile Rheumatoid Arthritis
___Allergies ***see below***	___Down Syndrome	___Neuromuscular Disease	___Sickle Cell Anemia
___Asthma ***see below***	___Epilepsy/Seizures ***see below***	___Muscular Dystrophy	___Ulcers/Gastric Reflux
___Autism	___Heart Problems ***see below***	___Orthopedic Disability	
___Cerebral Palsy	___Hemophilia/Bleeding Disorder	___Psychiatric Disorder	
___Cystic Fibrosis	___Leukemia/Cancer	___Renal/Kidney Disease	

FOR CONDITIONS CHECKED ABOVE, PLEASE PROVIDE ADDITIONAL INFORMATION BELOW:

ADD/ADHD	Does your child require medication, for this condition, to be taken at school: **___NO ___YES***
Allergies	Does your child have any of the following allergies: **___Bees ___Food ___Medication ___Seasonal** If yes, please list specific allergen and reaction (hives, swelling, vomiting, difficulty breathing, etc): _____ _____ Date of last allergy episode: _____ Is emergency medication required at school? **___NO ___YES***
Asthma	Date of last asthma episode: _____ Is medication or treatment required at school? **___NO ___YES*** List medications used to treat an asthma episode: _____ Does your child require an Asthma **Individual** Health Plan at school? **___NO ___YES**
Diabetes	Which type? **___ Type 1 ___ Type 2** How is it controlled? **___ Oral medication ___ Insulin ___ Diet** Is medication or treatment required at school? **___NO ___YES***
Seizures	Date of last seizure: _____ Type of seizures: _____ Is student aware of impending seizures? **___NO ___YES** Is rescue medication required at school? **___NO ___YES***
Heart Problems	Check type: **___Functional Heart Murmur ___Heart Valve Condition ___Other_____** Is exercise limited? **___NO ___YES***
Neuromuscular Disease / Orthopedic Disability	Name of problem: School Concerns:
Other Health Concerns	Name of problem: School Concerns:
Other Health Concerns/ Disability	Name of Problem: _____ School Concerns: _____

*** Indicates that additional physician documentation may be required. See school nurse for information and/or forms.**

I understand that in a health or safety emergency, involving my child, school officials may share confidential health information to appropriate and necessary health, safety or welfare officials.

_____

Signature of Parent/Guardian Date