

Student Health Assessment

(To be completed by Parent or Guardian)

Sacred Heart of Jesus School

Annual Health Assessment 2020-2021

Student's name: _____ Grade: _____ Age: _____ Birthdate: _____ M/F

1. Does your child have any medical conditions/injuries currently under treatment?
Y/N Explain: _____
2. ADD/ADHD Medication? Name/dose/time of medication given: _____
3. Asthma? Y/N Inhaler at school? Y/N
4. Does your child have allergies? Y/N Epi Pen at school? Y/N Food ___ Medicine ___
Animals ___ Seasonal ___
Please list the allergen(s): _____
5. Does your child have Diabetes? Y/N If yes, age at diagnosis: _____
6. Does your child have hearing problems? Y/N If yes, hearing aid? Y/N Tubes in ears?
Y/N
7. Does your child have speech problems? Y/N If yes, receiving speech therapy? Y/N
Where? _____
8. Does your child have frequent headaches/migraines? Y/N
9. Does your child have learning disabilities? Please explain: _____
10. Does your child wear glasses/contacts? Y/N Farsighted ___ Nearsighted ___
Lazy eye ___ Astigmatism ___
11. Does your child have epilepsy or a seizure disorder? Y/N
12. Does your child have celiac disease? Y/N
13. Does your child have any physical limitations? Y/N If yes, please explain: _____
14. School attended last year: SHOJ ___ Other _____
15. Are there any factors that the school nurse counselor or teacher should know about
which might affect your child's school experience? _____

I know of no health reason (s), other than information indicated on this form, why my child should not participate in any school activities.

Pediatrician: _____ Phone number: _____

Dentist: _____ Phone number: _____

Signature of parent: _____ Date: _____