

KNOB NOSTER R-VIII HEALTH ASSESMENT FORM

Student's Name: _____ Grade: _____
Date of Birth: _____ Age: _____ Gender: _____

The following information will allow the school staff to identify and care for your child's individual health care needs while at school. If your child does not have any special health care needs, please complete this form by marking "My child has no special health care needs" and sign and date at bottom of the form.

My child has no special health care needs

Please indicate if any of the following are relevant to your child. Provide additional information for the following conditions in the space provided.

ASTHMA?	<input type="checkbox"/> YES	Diagnosed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date? _____
		Triggered by _____	Treatment _____
ALLERGIES?	<input type="checkbox"/> YES	To medication, food, insects, pollen? Please list: _____	
		Has this required emergency action in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Is medication required at home? <input type="checkbox"/> Yes <input type="checkbox"/> No	At school? <input type="checkbox"/> Yes <input type="checkbox"/> No
STING ALLERGY?	<input type="checkbox"/> YES	Need emergency medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	List: _____
DIABETES?	<input type="checkbox"/> YES	Takes insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date/age diagnosed _____
		Daily testing at school? <input type="checkbox"/> Yes <input type="checkbox"/> No	Daily snacks? <input type="checkbox"/> Yes <input type="checkbox"/> No
SEIZURES?	<input type="checkbox"/> YES	Age of onset _____	Describe seizures _____
		Date of last seizure _____	
BONE/JOINT CONDITION?	<input type="checkbox"/> YES	Describe _____	
		Any physical restriction? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe _____
OTHER ILLNESS/ INJURY	<input type="checkbox"/> YES	Describe _____	

***If you answered YES to any of the above questions, please meet with the school nurse to set up an Emergency Action Plan or to set up meeting to arrange for an Individualized Health Care Plan.*

Emotional/Behavioral Disorder? Yes No Describe _____
 ADHD Autism Spectrum Bipolar Depression OCD ODD
Other _____

Takes daily medication? Yes No At home? Yes No At school? Yes No
Emergency Only? Yes No

Name of medication _____ Dosage _____
Reason _____

If a student requires medication at school, please obtain the appropriate form in the school health office. Parents must deliver all medication to the school in a properly labeled pharmacy bottle with a signed request for administration.

HEARING: Does your child: require preferential seating? Yes No wear a hearing aid? Yes No
VISION: Does your child: wear glasses? Yes No wear contacts? Yes No

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, this may be obtained.

Parent/Guardian Signature _____ Date _____