KNOB NOSTER R-VIII HEALTH ASSESSMENT 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?	☐ YES	Diagnosed by a doctor? ☐ Yes ☐ No Date?_______________________ Triggered by_______________________Treatment_________________________
ALLERGIES?	☐ YES	To medication, food, insects, pollen? Please list:___________________________ Has this required emergency action in the past? ☐Yes ☐No Is medication required at home? ☐ Yes ☐No At school? ☐Yes ☐No
STING ALLERGY?	☐ YES	Need emergency medication? ☐Yes ☐No List:____________________________
DIABETES?	☐ YES	Takes insulin? ☐Yes ☐No Date/age diagnosed ___________________________ Daily testing at school? ☐Yes ☐No Daily snacks? ☐Yes ☐ No
SEIZURES?	☐ YES	Age of onset_________Describe seizures __________________________________ Date of last seizure____________________
BONE/JOINT CONDITION?	☐ YES	Describe ____ Any physical restriction? ☐Yes ☐No Describe___________________________
OTHER ILLNESS/ INJURY	☐ 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______________________