

KEYPORT PUBLIC SCHOOLS HEALTH ASSESSMENT FORM

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

Please print

Name of Student (Last, First, Middle)	Birth Date	Sex
Address (Street)	Home Telephone Number (including area code)	
(Town and Zip Code)	Student's Physician or Primary Health Care Provider	
Parent/Guardian (Last, First, Middle)	Parent/Guardian (Last, First, Middle)	

Part I – To be completed by parent - *Important: Complete Part I before your child is examined.* Take this form with you to the health care provider's office.

Please check yes or no to the following questions (explain all "yes" answers in the space provided below.)

- | | Yes | No | |
|-----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health (eating and sleeping habits, weight, teeth, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any other specific illness, physical deformity or problem (asthma, diabetes, heart murmur, seizures, etc.)? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any restrictions on physical activity? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, etc.)? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medication (daily or occasionally)? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, or major illness (specify problem)? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any significant injury or accident (specify problem)? |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Are you claiming exemption from immunization guidelines? |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Have there been any recent changes in the family (relocation, death, divorce, etc.)? |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the school nurse? |

This child is number _____ of _____ children.

(Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.)

I give permission for release of essential information on this form for confidential use in the school for meeting my child's health and educational needs.

Signature of Parent/Guardian

Date

(To be maintained in student's Cumulative School Health Record)
(OVER)

Part II – Medical Evaluation

To the Health Care Provider: Please complete and sign.

Student's Name: _____

Screening/Test Results	Immunization Record
Note: *Mandated Screening/Tests/Immunizations	Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school

