PART 1 HEALTH ASSESSMENT
– To be completed by parent/guardian –

Student Name (Last, First Middle) _____ Birth Date ___/___/___ School Name _____ Grade _____

Address (Street, City, State, Zip) _____ Phone Number ___-___-___

Parent/Guardian (Male) _____ Parent/Guardian (Female) _____

Physician/Nurse Practitioner Name and Address _____

Dentist Name and Address _____

Other source(s) from which the student receives health care. (If none, write "None.") _____

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, does your child have any problems that may affect his/her learning in school, cause any concern and/or be important for school staff to know? Please check (✓) "Yes," or "No" for each of the following:

	Yes	No	Comments
Allergies (Drugs, Food, Insects)			describe reaction
Asthma			
Behavior or Emotional Problem			
Birth Defects			
Bladder Problem			
Bleeding Problems			
Bowel Problems			
Cerebral Palsy			
Concussion (Head Injury)			
Diabetes			
Ear Problem or Deafness			
Eye or Vision Problems			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning			
Limits on Activity			
Medication			
Meningitis			
Prematurity			
Seizures			
Sickle Cell Disease			
Speech Problem			
Surgery			

If you would like to discuss your child's health with school or school health personnel, please check title:
☐ Nurse assigned to school ☐ Teacher ☐ Counselor ☐ Principal

I give my permission for confidential and discreet use of Part 2, the health evaluation completed by the physician/nurse practitioner, to meet my child's health and educational needs in school. (Check (✓) one) ☐ Yes ☐ No

_____ ___/___/___
Signature, Parent/Guardian Date

IMPORTANT: Schedule an appointment for a medical examination of your child; share the above information with the physician or nurse practitioner, have him/her complete Part 2 after the examination and then return the form to the school.

*Adapted for use by the Archdiocese of Washington's Catholic Schools in Maryland.

ARCHDIOCESE OF WASHINGTON
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