STUDENT HEALTH ASSESSMENT FORM

(PLEASE PRINT CLEARLY)

STUDENT INFORMATION:

Student Name: _____

Date of Birth: _____ Age: _____ Sex: Male Female

PHYSICIAN INFORMATION:

Physician Name: _____

Physician Address: _____

_____

Physician Phone: _____

HEALTH INSURANCE INFORMATION:

Company Name: _____

Company Phone: _____

Group Number: _____ Contract Number: _____

Does the student have any past history or present problems with the following (circle all that apply):

Where appropriate, please indicate how often (e.g., for headaches) or the date(s) (e.g., for chicken pox).

Asthma	Environmental Allergies	Food Allergies	Diabetes
Latex Allergies	Heart Problems	Hepatitis	Hearing Problems
Headaches	High Blood Pressure	Seizures	Vision Problems
Bone Injuries	Muscular Injuries	Surgeries	Chicken Pox/Shingles

Other Medical Problems or Special Needs (Please describe): _____

_____

Additional Comments/Information: _____

_____

Is your child currently on any medications? Yes No

If yes, please list medication name(s), dosage, and frequency: _____

_____

Does the student have any known allergies to medications? Yes No

If yes, please list the medication name(s): _____