



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): _____