



Grade _____

New Student Health Assessment

Name _____ Date of Birth _____

1. Does your child have any Cardiac Problems?

If yes, Explain _____

2. Does your child have any chronic or acute physical or health considerations?

If yes, Explain _____

A. Physical Limitations? Explain _____

B. Special Classroom Considerations? Explain _____

C. Self-Sufficient in the restroom? _____ (If not, prepare and coach)

School policy requires the parents to be called to the school to clean and change the child.

3. What is your child's primary language? _____

To what extent does the child understand English? _____

Your child's safety is always our primary concern.

4. Does your child have any special dietary considerations? _____

Or allergies to:

A. Seasonal: _____

B. Medication: _____

C. Food: _____

D. Other: _____

5. Does your child have asthma? _____ If yes:

A. What is the treatment? _____

B. Is there a need for medication in school? _____ If yes:

Explain _____

(Explain medication policy and provide Doctor's orders form and IHP if necessary)

6. What medication is your child currently taking? _____

7. Will medication be needed in school? _____ Reason? _____

8. Does your child have a condition which is treated at home or school that would need to be addressed in our 3-day crisis plan? _____ (A supply of special food, hydration or medication to be kept in school for a 3-day shelter-in-place emergency situation.)

Parent's Names: _____

Address: _____

Phone: _____

Signature: _____ Date: _____