ASSESSMENT OF HEALTH AND PHYSICAL STATUS

Please return this form with the other enclosed forms.
All health information is confidential and will be forwarded to the school nurse.

Student: _____ M F Birthdate: _____

Parent/Guardian: _____ Date Completed: _____

___ Initial Evaluation (Complete ALL Sections)
___ Re-Evaluation (Complete Sections B - D)
___ Annual Update/IEP (Complete Section B - D)

A. HEALTH HISTORY (Please complete with initial evaluation history only).

Pre/Postnatal History:

- Please note anything unusual about the pregnancy, labor, and/or delivery: _____
  _____
- Was your child exposed to any of the following during pregnancy:
  Prescription medications Alcohol Over-the-counter medications _____
  Marijuana Tobacco Other illegal substances _____
  Other chemical exposure _____
- What, if any, special medical care did your child require at birth or during the first year: _____
  _____

Please list, including dates:

- Childhood illnesses/injuries: _____
  _____
- Hospitalizations/surgeries: _____
  _____
- Chronic health conditions: _____
- List any concerns with developmental and/or growth history: _____

Family Health History:

Diabetes	Asthma/Allergy	Genetic/Inherited Diseases
Mental Illness	Attention/Behavior	Learning Disability
Other: _____		Other: _____

Comments: _____

B. CURRENT HEALTH STATUS

Please list all/updated:

- Medical diagnosis/health conditions: _____
  _____
- Mental health diagnosis/concerns: _____
  _____
- Treatments: _____
- Alternative therapies: _____
- Past medications: _____
- Current medications: _____
  _____
- Allergies (reaction/treatment): _____
  _____

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Please list all Health Care providers/services that your child has received:

Name	Specialty	Clinic/Location	Phone Number	Date of Last Visit

Last known hearing test: _____ Results: _____ Concerns: Yes No
Last known vision test: _____ Results: _____ Concerns: Yes No
Any additional health information you would like to provide: _____
_____

C. DAILY LIVING

- Describe your child's sleep pattern: Bedtime: _____ Awakes: _____
- List any problems with sleep: _____
- Nutrition/Special dietary needs: _____
- Does your child require assistance with any of the following:
- Feeding Elimination/toileting Self-Care Skills _____
- Activity/Mobility
- Does your child have any physical restrictions (stairs, PhyEd, mobility, heat/cold, etc)? Yes No

_____

- Is there a need to modify your child's schedule? Yes No
- Menses (onset/frequency/duration/pain): _____

D. SCHOOL SETTING

- Does your child have any health related attendance concerns? Yes No
- Does your child have any specific health or medical concerns that may impact their education? ____

_____

- What do you see as your child's health or medical strengths and/or weaknesses? _____

_____

Health status/condition(s) that:

- May interfere with learning: _____
- May result in an emergency: _____

Signature of person completing form: _____

Relationship to student: _____