SAINT MARGARET SCHOOL

PART 1 – HEALTH ASSESSMENT FOR PARENTS

To be completed by parent or guardian

Student's Name (Last, First, MI)		Birthdate (Mo. DayYr.)	**Sex (M/F)**	**Grade**

Address (Number, Street, City, State, Zip) **Phone No.**

Parent/Guardian Names

Where do you usually take your child for routine medical care? **Phone No.**
Name: **Address:**

When was the last time your child had a physical exam? **Month** **Year**

Where do you usually take your child for dental care? **Phone No.**
Name: **Address:**

ASSESSMENT of STUDENT HEALTH

To the best of your knowledge has your child any problem with the following? Please √

	Yes	**No**	**Comments**
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problems or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning/Exposure			
Learning problems/disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problems with Coughing			
Seizures			
Serious Allergic Reactions			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication:
No___ Yes___ Names(s) of Medications:_____

Is your child on any special treatments? (nebulizer, epi-pen, etc)
No___ Yes___ Treatment_____

Does your child require any special procedures? (catheterization, etc.)
No___ Yes___

Parent/Guardian Signature_____ Date:_____

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