STUDENT HEALTH ASSESSMENT

Confidential Information

School: St. Mary's Springs Academy **School Year: 2021- 2022**

The following is a brief health form that must be returned to the Health Services Coordinator or office **by Tue 9/7/2021.** This information will be reviewed and used to meet your child's health needs at school.

Student's Name: _____

Date of Birth: _____ *(First, Middle Initial, Last)*

Gender: ___ Male ___ Female **Grade: _____**

Teacher:_____

Please list student's current medications:

You may treat my child with the following first aid medications: Wound Cleanser, Burn Spray or Gel, Hydrocortisone Cream, Saline eye drops and Vaseline _____YES _____NO **SIGNATURE:**

_____

Please check below any conditions your child has:

___ MY CHILD HAS NO HEALTH CONDITIONS

___ADD/ADHD ***see below*** ___Diabetes ***see below*** ___Migraine Headaches ___Juvenile Rheumatoid Arthritis ___Allergies ***see below***

___Neuromuscular Disease ___Sickle Cell Anemia ___Asthma ***see below*** ___Epilepsy/Seizures ***see below*** ___Muscular Dystrophy

___Ulcers/Gastric Reflux ___Autism ___Heart Problems ***see below*** ___Orthopedic Disability

___Cerebral Palsy ___Hemophilia/Bleeding Disorder ___Psychiatric Disorder

___Cystic Fibrosis ___Leukemia/Cancer ___Renal/Kidney Disease

FOR CONDITIONS CHECKED ABOVE, PLEASE PROVIDE ADDITIONAL INFORMATION BELOW:

ADD/ADHD	Does your child require medication, for this condition, to be taken at school: **___NO ___YES***
Allergies	Does your child have any of the following allergies: **___Bees ___Food ___Medication ___Seasonal** If yes, please list specific allergen and reaction (hives, swelling, vomiting, difficulty breathing, etc): _____ _____ Date of last allergy episode: _____ Is emergency medication required at school? **___NO ___YES***
Asthma	Date of last asthma episode: _____ Is medication or treatment required at school? **___NO ___YES*** List medications used to treat an asthma episode:_____ Does your child require an Asthma **Individual** Health Plan at school? **___NO ___YES**
Diabetes	Which type? **___ Type 1 ___ Type 2** How is it controlled? **___ Oral medication ___ Insulin ___ Diet** Is medication or treatment required at school? **___NO ___YES***

Seizures	Date of last seizure: _____ Type of seizures: _____ Is student aware of impending seizures? **___NO ___YES** Is rescue medication required at school? **___NO ___YES***
Heart Problems	Check type: **___Functional Heart Murmur ___Heart Valve Condition** **___Other**_____ Is exercise limited? **___NO ___YES***
Neuromuscular Disease / Orthopedic Disability	Name of condition: School Concerns:
Other Health Concerns	Name of condition: School Concerns:
Other Health Concerns/ Disability	Name of condition: School Concerns:
*** Indicates that additional physician documentation may be required. Before medication (prescription or over-the-counter) can be allowed at school, a Physician's Order/Parent Consent form must be completed.**	

I understand that in a health or safety emergency, involving my child, school officials may share confidential health information to appropriate and necessary health, safety or welfare officials.

Signature of Parent/Guardian: **Date:**