

STUDENT'S HEALTH APPRAISAL FORM 2015-2016

Student's Name _____ Grade in 2015-16 _____

PARENT/GUARDIAN'S EVALUATION OF PUPIL'S HEALTH

Please answer the following questions about your son or daughter:

1. Is your child subject to any condition which may result in a classroom emergency? Yes ___ No ___
 - a. Allergic reaction? Yes ___ No ___

To what? _____
 - b. Asthma? Yes ___ No ___
 - c. Epilepsy? Yes ___ No ___

Medication: _____
 - d. Diabetes? Yes ___ No ___
 - e. Heart condition? Yes ___ No ___

Describe: _____
2. At present, is your child under the care of a doctor for a particular illness or on any medication? Yes ___ No ___

If yes, please state illness and/or medication: _____
3. Does your child wear glasses? ___ Contact lenses? ___ How long? ___ Yes ___ No ___

When were glasses/contact lenses last changed? _____
4. Does your child have a hearing loss at the present time? Yes ___ No ___

Has your child had any ear infections during the past year? Yes ___ No ___
5. Has your child ever had a severe injury that could affect his/her school participation? Yes ___ No ___

If yes, please explain: _____
6. Has your child ever had any major operations? Yes ___ No ___

If yes, please explain: _____
7. Are there any mental or emotional problems that could affect his/her participation in school? Yes ___ No ___

If yes, please explain: _____
8. Has your child had a dental examination in the past year? Yes ___ No ___
9. Has your son/daughter had a physical examination in the past year? Yes ___ No ___
10. Does your child have a speech problem? Yes ___ No ___

If yes, please explain: _____
11. Is your recommendation for physical activity: Unrestricted _____ Restricted _____

If restricted, please explain: _____
12. Other comments concerning health: _____

Parent/Guardian Signature _____

Date _____