# Jefferson C-123
# Health Assessment
# for New Students

Today's Date: _____

Child's Name:_____ Birth date: _____ Sex: M☐ F☐

Address:_____ City:_____ Home Phone: _____

Who does your child live with? Both Parents☐ Mother☐ Father☐ Other☐

Who is your child's physician? _____ Last Visit? _____

Who is your child's dentist? _____ Last Visit?_____

Does your child have: Private Insurance ☐ Medicaid ☐ No Insurance ☐

Past Health History

Any problems during birth, such as premature, lack of oxygen, need for resuscitation, meconium stained fluid, birth weight below 5 lbs. 8 oz., etc. ☐ Yes ☐ No If yes, please explain.

Did the mother smoke, drink alcohol or use any recreational drugs during the pregnancy?☐Yes ☐No
If yes, please explain.

Any communicable diseases such as chicken pox, measles, scarlet fever, hepatitis, etc.? ☐ Yes ☐ No
If yes, please explain.

Has your child had:

| | | | |
|---|---|---|---|
| Date:_____ | Meningitus? | Date:_____ | Strep infections? |
| Date:_____ | Pneumonia/lung problems? | Date:_____ | Ear infections? |
| Date:_____ | Asthma? | Date:_____ | Seizures? |
| Date:_____ | Heart problems? | Date:_____ | Diabetes? |

Does your child take any medications on a regular basis? ☐ Yes ☐ No

Medication:_____ Why?_____ Dosage:_____ Frequency?_____

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Any physical limitations? ☐ Yes ☐ No. If yes, please explain:

Activity/Exercise

Does your child have enough energy to do what he/she needs to during the day? ☐ Yes ☐ No.

Fatigue easily? ☐ Yes ☐ No. Difficulty breathing with exertion? ☐ Yes ☐ No.

Please list activities, sports/non-sports, that your child enjoys and explain any concerns.

Cognition/Perception

Does your child seem to have adequate short term/long term memory for his/her age?☐ Yes ☐ No

Has your child ever been diagnosed with ADD/ADHD? ☐ Yes ☐ No

Eyes

Does your child squint or complain of double vision? ☐ Yes ☐ No

Does your child have problems with watery, crusty eye lids or redness of the eye? ☐ Yes ☐ No

Does your child have frequent headaches? ☐ Yes ☐ No

Does your child turn or tilt head to use only one eye? ☐ Yes ☐ No

Does your child wear glasses or contacts? ☐ Yes ☐ No If yes, which?

Where does your child sit in their classroom? _____

Please explain any of the above if you answered yes.

Ears

Has your child in the past or currently have tubes in his/her ears? ☐ Yes ☐ No

Does anyone who lives in your household smoke? ☐ Yes ☐ No

Does your child have a hearing aid? ☐ Yes ☐ No

Does your child need the volume turned up in order to hear when watching TV or listening to the radio? ☐ Yes ☐ No

Sleep/Rest

Is your child able to sleep through the night? ☐ Yes ☐ No If now, what wakes him/her?

General Health

Do your consider your child healthy? ☐ Yes ☐ No If no, please explain.

Allergies to any dyes, food, medications, animals or insects? ☐ Yes ☐ No

If yes, what are the allergies?_____

What type of reaction? _____

How do you treat the reaction?_____

Any surgeries of hospitalizations in the past? ☐ Yes ☐ No If yes, please explain.

Nutrition/Metabolism

How is your child's appetite? ☐ Good ☐ Fair ☐ Poor

Is your child on a special diet? ☐ Yes ☐ No

Do you consider your child a picky eater? ☐ Yes ☐ No

Does your child's hair, nails and skin appear healthy to you? ☐ Yes ☐ No

For example: shiny hair, nails and skin without lesions or growths, nails that aren't peeling.

Any problems with indigestion, swallowing or frequent vomiting? ☐ Yes ☐ No If yes, please explain.

Self-Concept

If female, has your child began her menstrual period? ☐ Yes ☐ No

Are there any concerns your daughter has about how her body is changing? ☐ Yes ☐ No

If yes, please note.

If male, does he have any concerns about how his body is changing? ☐ Yes ☐ No

If yes, please note.

Would you like for the school nurse to contact you personally? ☐ Yes ☐ No

The following are standing order medications and treatments that may be administered to your child at school with your permission only. This form is valid for the current school year and gives permission for treatment by the school nurse or one of the trained health designees.

**Please put an (X) beside each medication/treatment that your child has permission to receive:**

☐ Ibuprofen 200-400 mg (minor pain, headache, fever, cramps, injuries)

☐ Tylenol 325-650 mg (minor pain, headache, fever, cramps)

☐ Caladryl Lotion (minor itching)

☐ Hydrocortisone Cream (minor itching)

☐ Benadryl 12.5 - 25 mg tablet or liquid (mild allergic reactions)

☐ Triple Antibiotic Ointment (applied to minor cuts and abrasions)

☐ Peroxide (used to clean minor cuts and abrasions)

☐ Sterile Saline Eyewash (minor eye irritation)

☐ Blistex or Vaseline (dry, chapped lips)

☐ Orasol gel or Anbesol (cold sores, fever blisters, toothache)

☐ Aloe Vera spray/gel or Solarcaine (minor sunburns or burns)

☐ Tums (minor abdominal discomfort, indigestion)

☐ Peppermint (nausea, sore throat, cough)

☐ Throat Lozenge/Fruit Breezer (minor cough, throat irritation)

_____ _____

Parent/Guardian Signature Date