LINCOLN CHRISTIAN SCHOOL

ASSESSMENT OF STUDENT HEALTH

2011/2012 Academic School Year

TO BE COMPLETED FOR ENROLLING A NEW STUDENT AT ANY GRADE, AND FOR ALL STUDENTS ENTERING GRADE 6

Student's Last Name | First Name | Middle Name | Grade

Street Address | City | State | Zip

Cell Phone Number | Home Phone Number | Email

Father/Legal Guardian's Name | Work Phone | Cell Phone

Mother/Legal Guardian's Name | Work Phone | Cell Phone

Doctor's Name | Office Phone | Address

Date of Last Visit | Reason for Last Visit

Dentist's Name | Office Phone | Address

Date of Last Visit | Reason for Last Visit

List Any Additional Healthcare Providers/Services of the Student's

To the best of your knowledge, does the student have any problems which may affect his/her learning in school, cause you any concern, or any areas which may be important for the school staff to know? Please check "no" or "yes" for each of the following questions:

1. Does the student have any known drug allergies? ☐ No ☐ Yes
2. Any known food, substance, chemical, animal, insect, or seasonal allergies? ☐ No ☐ Yes
3. Do you have any concerns about your child's general health (eating and sleeping habits, bowel or bladder, posture, teeth, skin, menstruation, weight, etc.)? ☐ No ☐ Yes
4. Any eye problems (difficulty seeing, crossed eyes, frequent reddening or watery eyes, wears glasses/contact lenses)? ☐ No ☐ Yes
5. Any ear or hearing problems (frequent ear aches, difficulty hearing, draining ear, use of a hearing aid, etc.)? ☐ No ☐ Yes
6. Any speech problems (difficulty having speech understood, stammering, delayed speech development, etc.)? ☐ No ☐ Yes
7. Does your child have any other specific illness or issue which might, in your opinion affect his/her school performance or program? ☐ No ☐ Yes
8. Has your child received any medical or other evaluation, the findings of which could help school personnel in meeting his/her academic needs? ☐ No ☐ Yes
9. Does your child require any specific health care during school? ☐ No ☐ Yes
10. Do you have any concerns about your child's developmental behavior or emotional well being of which the school should be aware? ☐ No ☐ Yes

If answered "yes" to any of the questions above, please explain in detail: ____________________

List **ALL** current medications, inhalers, epipens, etc: ____________________

Student's Last Name ______ First Name ______ Middle Name ______ Grade ______

STUDENT'S HEALTH HISTORY

If checking "yes" on any of the answers below, please indicate year of occurrence.

	No	Yes	Year		No	Yes	Year
Chicken Pox	☐	☐	______	T.B. Contact	☐	☐	______
Measles	☐	☐	______	Diabetes	☐	☐	______
Rubella (3-day measles)	☐	☐	______	Allergies	☐	☐	______
Mumps	☐	☐	______	Frequent Colds/Sore Throats	☐	☐	______
Rheumatic Fever	☐	☐	______	Ear Infections	☐	☐	______
Heart Defect	☐	☐	______	Surgery	☐	☐	______
Convulsions	☐	☐	______	Nosebleeds	☐	☐	______
Persistent Cough	☐	☐	______	Frequent Headache	☐	☐	______
Frequent Toilet Use	☐	☐	______	Frequent Stomach Ache	☐	☐	______
Toothaches	☐	☐	______	Bed Wetting	☐	☐	______
Angers Easily	☐	☐	______	Worries Excessively	☐	☐	______
Nervousness	☐	☐	______	Tires Easily	☐	☐	______

If further description of any above illness or issue is needed, please list: ______

If student has a history of other illness or issue is not listed above, please occurrence and date (if applicable): ______

If you feel the staff members working directly with this student should not have access to his/her Health Assessment, please explain (Note: student information will be managed professionally and with the appropriate level of confidentiality): ______

Signature of Parent/Legal Guardian ______ Date ______

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