Please complete this Student Health form as soon as possible

ASSESSMENT OF STUDENT HEALTH To the best of your knowledge, has the participating student had any problem with the following?			
	Yes	No	Comments
Anaphylaxis			
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problem or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where, Why)			
Lead Poisoning/Exposure			
Learning problems/ disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Serious Allergic Reactions			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does the participant take any medication? □ No □ Yes
Name(s) of Medications:

_____

Will the participant require any medication to be administered in class? □ No □ Yes
Name(s) of Medications:

_____

Will the participant require any emergency medications (epinephrine auto-injectors, inhalers, glucagon, Diastat, nebulizer medication) to be administered in class? □ No □ Yes, please list

Parent/Guardian/Participant Signature _____
Date _____