**USD 508 SCHOOL NURSE HEALTH ASSESSMENT FORM**

Confidential: To be filled out by parent or guardian:

**Student’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_ Sex: M\_\_\_\_\_\_ F\_\_\_\_\_\_**

**(please print)**

**Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth date \_\_\_\_\_\_\_\_\_\_\_**

**Mother’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Please print)**

**Father’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Please print)**

**Student lives with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does Child have insurance? Yes or No Private or other \_\_\_\_\_\_\_\_\_\_\_**

**Does your child have food allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medicine allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Environmental allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child take medicine at home? Yes \_\_\_\_\_ No \_\_\_\_\_\_ Name of Med. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is your child required to take medicine during school hours? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_**

***If child is required to take medicine during school hours, the appropriate forms must be filled out by the parent and the physician.***

Are your child’s immunizations up to date? \_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_ No

**Please check those that apply:**

\_\_\_\_\_Bone or joint disease and/or injury \_\_\_\_\_Back/spine problems (Scoliosis, etc)

\_\_\_\_\_Fainting \_\_\_\_\_Head injuries

\_\_\_\_\_Heart disease \_\_\_\_\_Hyperactivity

\_\_\_\_\_Hypertension (high blood pressure) \_\_\_\_\_Asthma or breathing problems

\_\_\_\_\_Hypoglycemia (low blood sugar) \_\_\_\_\_Kidney disease or urinary infection

\_\_\_\_\_Throat infections (recurring)

Diabetes/Pre-diabetes Initial diagnosis date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Required medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Convulsive Disorders: \_\_\_\_ Grand Mal \_\_\_\_ Petit Mal \_\_\_\_Required Medication\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental: Orthodontics (braces) \_\_\_\_\_\_\_ Dentures \_\_\_\_\_\_\_\_

(Continued on Back)

Ear Infections: Tubes inserted \_\_\_\_\_\_\_ Removed \_\_\_\_\_\_\_ Hearing Loss \_\_\_\_\_\_\_

Hearing impairment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision: Glasses \_\_\_\_\_\_\_ Contact Lenses \_\_\_\_\_\_ Surgery \_\_\_\_\_\_

Note any type of health appliance the child may use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other chronic disorders not mentioned above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments or explanations of illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of last physical exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I give my consent for immunization information to be added to the Kansas Web IZ program for the purpose of assessment and reporting. This consent will remain in affect while my child attends USD 508, unless revoked by written request.***

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sign Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_