South Central District Health
Keeping your family & community healthy

Student Health Assessment

Student's Name (Last, First, Middle)	Birthdate	Grade
Address (Number, Street, City)		Phone Number
Parent/Guardian		
Physician Name and Phone		
Dentist Name and Phone		

Assessment of Student Health		
To the best of your knowledge, does your child have any problems which may affect his/her learning in school, cause you any concern, and/or may be important for school staff to know. Please check "yes" or "no" for each of the following questions.		
	Yes	No
1. Do you have any concerns about your child's general health (eating and sleeping habits, bowel or bladder, posture, teeth, skin menstruation, weight, etc.)?		
2. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes, wear glasses or contact lenses, etc.)?		
3. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, draining ear, use a hearing aid, etc.)?		
4. Does your child have any speech problems (difficulty having speech understood, stammering, delayed speech development, etc.)?		
5. Does your child have any allergies (foods, insects, drugs, pollen, etc.)?		
6. Does your child have any specific sickness or problems which might, in your opinion, affect his/her school performance or program?		
a. Has your child received any medical or other evaluation, the findings of which could help school personnel in meeting his/her health or education needs?		
b. Does this problem require any special health care in the school?		
c. Does your child take any medication?		
7. Do you have any concerns about your child's developmental behavior or emotional well-being of which the school should be aware?		

Remarks (please explain any "yes" answer)

∫ If you would like to discuss your child's health with a school person, please check title:
□ Nurse □ Teacher □ Counselor □ Principal