St. Andrew Catholic School Health Assessment

Child's name_____Grade_____DOB_____

Address_____

Urgent and Emergency Contacts:

Name, relationship, and best phone number, who should we call first:

#1_____

#2_____

#3_____

Child's Medical History

Including allergies, medications, illnesses, surgeries, or any impairments (physical or cognitive) to which the school nurse should be aware.

		if "Yes", detail treatment required
_____	Frequent Headaches	_____
_____	Seizures/Concussion	_____Date of last_____
_____	Glasses/Contacts	Worn daily_____Reading/Computer only_____
_____	Speech/Hearing	_____
_____	Heart/Rheumatic fever	_____
_____	Asthma	_____Inhaler needed (Y/N)_____
_____	Diabetes	_____
_____	Depression/Anxiety	_____
_____	ADD/ADHD	_____
_____	Muscle/Bone weakness	_____
_____	Stomach problems	_____
_____	MRSA	_____
_____	Allergies	____ Food(s)____ Medication(s)___ Seasonal
		_____
_____	Surgeries/Serious injuries/ Other Illnesses	_____