HEALTH ASSESSMENT RECORD

Child's Name_____ Date of Birth_____

To Be Completed by Parent/Guardian

Please answer these health history questions about your child before the physical examination:

Any health concerns	Y	N	Hospitalizations or Emergency Room Visits	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medications	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps or bridges	Y	N	Asthma treatment (past 3 yrs)	Y	N
Family History						Asthma treatment (past 5 yrs)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Seizure treatment (past 2 yrs)	Y	N
Any immediate family members have high cholesterol				Y	N	Diabetes	Y	N

Please explain all "yes" answers here. For illnesses/injuries, etc., include the year and/or your child's age at the time:

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Is there anything you want to discuss with the physician? Y N (If yes, please explain)_____

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Please list all medications your child currently takes_____

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I give Center for Pediatric Medicine permission to release and exchange information on this form between the school nurse and health care provider for confidential use in meeting with my child's health and educational needs in school:

_____ _____

Signature of Parent/Guardian Date