The Maryland School for the Blind

Parent

PART I – HEALTH ASSESSMENT

Health Center - School Year 2016-2017

To be completed by parent or guardian

|  |  |  |
| --- | --- | --- |
| Student’s Name (Last, First, Middle)      | Birthdate (Mo. Day Yr.)      | Sex (M/F)      |
| Address (Number, Street, City, Zip) Phone No.            |
| Parent/Guardian Names      |
| Where do you usually take your child for routine medical care? Name:       Address:       Phone No.       |
| Where do you usually take your child for dental care? Name:       Address:       Phone No.       |
| What other source does your child receive health care?Name:       Address:       Phone No.       |
| ASSESSMENT OF STUDENT HEALTHTo the best of your knowledge has your child had any problem with the following? Please check “Yes” or “No” for each of the following. |
|  | **Yes** | **No** | **Comments** |
| Allergies (Food, Insects, Drugs, Latex) | [ ]  | [ ]  |       |
| Allergies (Seasonal) | [ ]  | [ ]  |       |
| Asthma or Breathing Problems | [ ]  | [ ]  |       |
| Behavior or Emotional Problems | [ ]  | [ ]  |       |
| Birth Defects | [ ]  | [ ]  |       |
| Bleeding Problems | [ ]  | [ ]  |       |
| Cerebral Palsy | [ ]  | [ ]  |       |
| Dental | [ ]  | [ ]  |       |
| Diabetes | [ ]  | [ ]  |       |
| Ear Problems or Deafness | [ ]  | [ ]  |       |
| Head Injury  | [ ]  | [ ]  |       |
| Heart Problems | [ ]  | [ ]  |       |
| Hospitalization (When, Where) | [ ]  | [ ]  |       |
| 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 | [ ]  | [ ]  |       |
| If the answer to any of these questions is “Yes” then the physician needs to complete the order form.Does your child take any medication? No **[ ]**  Yes **[ ]**  Name of Medication      Is your child on any special treatments? (nebulizer, epi-pen, etc.) No **[ ]**  Yes **[ ]**  Treatment      Does your child require any special procedures? (catheterization, etc.) No **[ ]**  Yes **[ ]**  Please Describe      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent/Guardian Signature Date |

CD/LB/cic:5/2/16