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 HEALTH  To 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