

## School District 4J Student's Health Appraisal/Medical History Form Parent/Guardian Evaluation of Student's Health

<i>For office use only :</i>	Student's 4J Pupil #	
Student Name		
Date of Birth	Grade	
School		

1. Does your child have a physical handicap?	<input type="checkbox"/>	No
<input type="checkbox"/> Yes: <i>Nature of condition:</i>		

2. Has your child ever had an operation?	<input type="checkbox"/>	No
<input type="checkbox"/> Yes: <i>Type of operation?</i>		

3. Has your child ever had a severe injury?	<input type="checkbox"/>	No
<input type="checkbox"/> Yes: <i>Nature of injury</i>		
<input type="checkbox"/> Yes: <i>Date of injury</i>		

4. Does your child wear glasses?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
----------------------------------	--------------------------	-----	--------------------------	----

5. Doctor's name:	Ph
Dentist's name:	Ph
Date of last physical exam:	

6. Is your child currently under a doctor's care for an illness?	<input type="checkbox"/>	No
<input type="checkbox"/> Yes <i>Illness:</i>		

7. Is your child taking any medication?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Will your child take medicine at school?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<i>If yes, name of medication:</i>				
<i>For condition: (Please specify)</i>				

8. Does your child have any of the following?			
<input type="checkbox"/>	Asthma*	<input type="checkbox"/>	ADD/ADHD
<input type="checkbox"/>	Diabetes*	<input type="checkbox"/>	Hearing Loss
<input type="checkbox"/>	Heart Problem*	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Seizure Disorder*	<input type="checkbox"/>	Ear Infections
<input type="checkbox"/>	Severe Bee Sting Allergy*	<input type="checkbox"/>	Speech Disorder
<input type="checkbox"/>	Severe Food Allergy*	<input type="checkbox"/>	Allergies
* <b><i>If your child has any of the conditions in the upper left column, please ask office staff to provide the specific form for this condition: complete this form also.</i></b>			
Explain health conditions:			
Other health problems:			

9. Is your child able to participate fully in activities at school?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No ( <i>explain</i> )
---	--------------------------	-----	--------------------------	-----------------------

10. Has your child had Chicken Pox?	<input type="checkbox"/>	No
<input type="checkbox"/> Yes: <i>What year?</i>		

11. Country of birth:
-----------------------

12. Previous school:
----------------------

I understand that this form will be placed in my child's Health Folder and may be shared with 4J staff.	
Parent/Guardian Signature	Date