MSAD#49
NEW STUDENT SCREENING
HEALTH INFORMATION

Student Name_____**Parents/Guardians**_____

Birth date _____ _____

Physician_____ **Last Physical**_____

Dentist_____ **Last Seen**_____ **Insurance** (Y/N)_____

1. Please check any condition that your child has had and the year

CONDITION	NO	YES	YEAR	CONDITION	NO	YES	YEAR
Accident, serious				High Blood Pressure			
ADD/ADHD				Kidney Problems			
Asthma				Meningitis			
Birth Defect				Muscle Problems			
Blood Disorder				Nerve Problems			
Bone Problem				Nose Bleeds (frequent)			
Bronchitis, Chronic				Over or Under Weight			
Cavities				Rheumatic Fever			
Chicken Pox/Vaccine				Seizures or Convulsions			
Diabetes				Serious Illness			
Ear Infections (chronic)				Sleeping Difficulties			
Emotional Stress/Anxiety				Speech Problems			
Eye Problems/glasses				Toileting Concerns			
Fainting				Tonsillitis, Frequent			
Headaches (frequent)				Other Health Problems (List)			
Hearing Loss							
Heart Problems							

Please write a brief description for all "YES" answers:

2. List diagnosed **allergies**; Food, medicines, bee stings, or other and **treatment**:

(Continue on other side)

3. List any medications your child takes regularly, at home or school, and the reason for taking them :(any prescriptions, over-the-counter medication, vitamins, fluoride)

4. List any hospitalizations or operations your child has had and reasons for and dates of:

5. List Health Issues which would limit your child's participation in any school activities in the class room, in Physical Education, or in competitive athletics:

6. Were there any problems with the pregnancy or delivery of your child? If yes please explain:

7. Does anyone smoke in your home or car?

8. Are there any significant issues (family, emotional, or psychological) that we should know about to better meet the needs of your child?

IMMUNIZATIONS: You must provide a copy of your student's immunization record.

_____ _____

Date **Signature of Parent or Guardian**