



ENGLEWOOD PUBLIC SCHOOLS HEALTH ASSESSMENT

Name: _____

Last

First

Middle Initial

Date of Birth

Does your child have a history of the following:

Yes **No**

- | | | | |
|----|---|-------|-------|
| a. | Fainting with exercise | _____ | _____ |
| b. | Loss of consciousness after an injury? Seizures? | _____ | _____ |
| c. | Any previous joint injury? Injuries? Fractures? | _____ | _____ |
| d. | Diabetes? | _____ | _____ |
| e. | Heart problems? Chest pain? Palpitation? Murmurs? | _____ | _____ |
| f. | Allergies? Hives? | _____ | _____ |
| g. | Asthma: Does your child carry any inhaler? | _____ | _____ |

If yes, medication and dose:

- | | | | |
|----|--|-------|-------|
| h. | Surgery? Hospitalization? | _____ | _____ |
| i. | Chicken Pox? (Month/Year) _____ | _____ | _____ |

1. If you have checked yes to any of the above, please explain:

2. Does your child take any medication regularly? If yes, please list the medication, dosage, time taken, reason for taking the medication, and possible side effects below.

3. In case of an emergency, I hereby authorize the school to call the physician or dentist below.

Physician _____ Phone number _____

Dentist _____ Phone number _____

I give my permission for the school nurse to share all health information with the faculty as needed.

I give my permission for the school doctor to examine my child when needed.

Signature

Date