

The Maryland School for the Blind
PART I – HEALTH ASSESSMENT
Health Center - School Year 2011-2012

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