

XAVIER CATHOLIC SCHOOL HEALTH ASSESSMENT 2017-18



Please note: Information supplied is confidential. Information will be shared with staff on a need to know basis, as it affects your child's education.

Student's Last Name _____ Student's First Name _____ Birthdate _____ Sex _____ Grade _____
Print Print

Family Doctor _____ Dr. Phone Number _____

Does your child have a history of any of the following?

Breathing Problems: Asthma ___ Hyperventilates ___ Other _____

Uses: Inhaler ___ Nebulizer ___ At Home Only ___ At School ___ How Often _____

If student has asthma please fill out and return Asthma Action Plan

Allergies: Food _____ Reaction _____

Medication _____

Seasonal _____

Insect Bites _____

If student has food allergy please fill out and return Food Allergy Action Plan.

If student has insect bite allergy please fill out and return Insect Bite Action Plan.

Convulsive/Seizure disorder Yes _____ No _____

If student has a seizure disorder fill out and return Seizure Emergency Treatment Plan.

Other health concerns (i.e. Hospitalization, operations etc.) _____

Diabetes: Initial Diagnosis (date) _____

If student has diabetes please fill out Diabetic Action Plan

ADD/ADHD/ODD _____ Medication _____

Frequent Ear Infections: Age of onset (year) _____ Tubes inserted (year) _____

Hearing Loss (date) _____ Right: ___ Left: ___ Hearing Aide: _____

Heart, Cardiovascular disease, or High Blood Pressure _____

Head injuries or major accidents: (please explain) _____

Urinary/Bowel Problems: (please explain) _____

Other health concerns (i.e. Hospitalization, operations etc.) _____

Daily Medication taken at home: (please list drug/dose) _____

Daily medication taken at school: (please list drug/dose) _____

Wears Glasses/Contacts: Yes ___ No ___

I grant permission for my child to receive the following while in school:

Emergency medical care Yes ___ No ___

Acetaminophen Yes ___ No ___

Ibuprofen Yes ___ No ___

Antibiotic Ointment Yes ___ No ___

Anti-Itch Cream Yes ___ No ___

Diphenhydramine (Benadryl) Yes ___ No ___

Tums Yes ___ No ___

*Xavier will not administer ANY prescription medications without prescription label on bottle and permission signed by a parent/guardian. Students may NOT carry medications with them in school.

Parent/Guardians Signature: _____ Date: _____

Please feel free to write on back to describe in more detail your child's health care needs.

For Nurse/Office Only:

Date Received

Screening Date

Results

Vision _____

Pass ___ Fail ___

Hearing _____

Pass ___ Fail ___

Immunizations _____ Physical _____

Food Allergy Action Plan _____

Asthma Action Plan _____

Seizure Action Plan _____

Diabetic Action Plan _____

Insect Bite Action Plan _____