XAVIER CATHOLIC SCHOOL HEALTH ASSESSMENT 2018-2019

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 ____	Anti-Itch Cream	Yes ____ No ____
Acetaminophen	Yes ____ No ____	Diphenhydramine (Benadryl)	Yes ____ No ____
Ibuprofen	Yes ____ No ____	Tums	Yes ____ No ____
Antibiotic Ointment	Yes ____ No ____		

*Xavier will not administer give 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:

	Screening Date	Results	Date Received
Vision	_____	Pass _____ Fail _____	Immunizations _____ Physical _____
Hearing	_____	Pass _____ Fail _____	Asthma Action Plan _____
			Seizure Action Plan _____
			Diabetic Action Plan _____