XAVIER CATHOLIC SCHOOL HEALTH ASSESSMENT 2019-20

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.)______________________________
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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:

	Screening Date	Results
Vision	__________________________	Pass _____ Fail _____
Hearing	__________________________	Pass _____ Fail _____

Date Received

Immunizations ________________ Physical _________________
Food Allergy Action Plan _________________________________
Asthma Action Plan ____________________________________
Seizure Action Plan ____________________________________
Diabetic Action Plan ____________________________________
Insect Bite Action Plan __________________________________