# Sayville Public Schools
# Health Assessment Record

Name of Student(Last, First, Middle) _____ Birth Date: _____

Address: _____ Town _____ State _____ Zip code _____

Home Phone # _____ Parent: Mother: _____ cell # _____
Father: _____ cell # _____

Physician's Name: _____ Physicians Phone # _____

Health Insurance Company/Number/Medicaid # _____

## To Be Completed By Parent

**Please check answers to the following questions in columns on the left.**
**( Explain all "yes" answers in the space provided below)**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Do you have any concerns about your child's general health? ( eating., sleeping, teeth) |
| ☐ | ☐ | Has your child been diagnosed with any chronic disease? ☐Asthma, ☐Diabetes, ☐Seizures |
| ☐ | ☐ | Does your child have any allergies?( Food,Insects, Medication ,Latex, etc.) |
| ☐ | ☐ | Does your child take any medication? (daily or occasionally) |
| ☐ | ☐ | Does your child have any problems with vision, hearing or speech? (glasses,contacts, tubes, hearing aids) |
| ☐ | ☐ | Has your child had any hospitalization, operations, major illness or injury, or significant accident? |
| ☐ | ☐ | In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? |
| ☐ | ☐ | In the past 12 months, has your child experienced any difficulty with excessive weight lose, weight gain, or excessive thirst or urination? |
| ☐ | ☐ | Does your child have health insurance? |
| ☐ | ☐ | Does your child have dental insurance? |
| ☐ | ☐ | Would you like to discuss anything with the school nurse? |

**Please explain any yes answers here. Please include year and child's age at time of any illness/injury/etc.**

_____

_____

_____

**I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.**

_____ _____

**Signature of Parent/Guardian:** **Date:**

**REVISED: 11/6/12**