



Grade \_\_\_\_\_

## New Student Medical Assessment

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Does your child have any Cardiac Problems?

If yes, Explain \_\_\_\_\_

\_\_\_\_\_

2. Does your child have any chronic or acute physical or health considerations?

If yes, Explain \_\_\_\_\_

\_\_\_\_\_

A. Physical Limitations? Explain \_\_\_\_\_

B. Special Classroom Considerations? Explain \_\_\_\_\_

C. Self-Sufficient in the restroom? \_\_\_\_\_ (If not, prepare and coach)

**School policy requires the parents to be called to the school to clean and change the child.**

3. What is your child's primary language? \_\_\_\_\_

To what extent does the child understand English? \_\_\_\_\_

**Your child's safety is always our primary concern.**

4. Does your child have any special dietary considerations? \_\_\_\_\_

Or allergies to:

A. Seasonal: \_\_\_\_\_

B. Medication: \_\_\_\_\_

C. Food; \_\_\_\_\_

5. Does your child have asthma? \_\_\_\_\_ If yes:

A. What is the treatment? \_\_\_\_\_

B. Is there a need for medication in school? \_\_\_\_\_ If yes:

Explain \_\_\_\_\_

(Explain medication policy and provide Doctor's orders form and IHP if necessary)

6. What medication is your child currently taking? \_\_\_\_\_

7. Will medication be needed in school? \_\_\_\_\_ Reason? \_\_\_\_\_

8. Does your child have a condition which is treated at home or school that would need to be addressed in our 3-day crisis plan? \_\_\_\_\_ (A supply of special food, Hydration or medication to be kept in school for a 3-day shelter-in-place emergency situation.)

Parent's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_