Assessment of Student Health

*This form will be kept in a **confidential** file in the office of the Director of Education and shared with your child's teacher.*

Student's Name ____ Grade _______________

Does your child have any issues that may effect his/her learning in school, cause you a concern, and/or may be important for the school staff to know? Please check the *Yes*, *No* or *Not Sure* column for each of the following. **If *Yes*, please specify.**

Health & Learning Issues	Yes	No	Not Sure
General health (fatigue, low energy level, frequent illness)	❑	❑	❑
Specific physical conditions/illnesses in the past or present	❑	❑	❑
Allergy (food, drugs, insect stings, pollen):	❑	❑	❑
Vision/Eye (contact lenses, glasses, uncorrectable condition)	❑	❑	❑
Hearing/Ear (frequent infections, hearing loss, hearing aids)	❑	❑	❑
Speech (delay, articulation concerns)	❑	❑	❑
Reading or perceptual problems (difficulty in learning to read phonetically)	❑	❑	❑
Hyperactivity	❑	❑	❑
Attention (difficulty staying focused, short attention span)	❑	❑	❑
Social conduct/personal relationship (circle all that apply): needs to be center of attention, easily upset, shy, prefers to work alone, difficulty making friends, other	❑	❑	❑
Learning delays (circle all that apply): reading, writing, comprehension, organization, speech/language, attention, memory, other	❑	❑	❑
Major changes or disruptions in child's life	❑	❑	❑

Please include any medications that your child may be taking on a regular basis.____

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