

WOODSTOCK ELEMENTARY SCHOOL

HEALTH APPRAISAL FORM

Child's Last Name: _____ First: _____

Home Address: _____ Zip: _____

Date of Birth: _____ Gender: F M Home Phone: _____

Parent/Guardian Name: _____

Dear Physician,

Thank you for your assistance in preparing this child to begin his or her school career. We look forward to supporting him or her, both academically and physically, for many years to come!

HEALTH HISTORY

Does this child have any of the problems listed below?	YES	NO
1. Allergies or reactions: (for example: food, medication)		
2. Hay fever, asthma, or wheezing		
3. Eczema or frequent skin rashes		
4. Convulsions/Seizures		
5. Heart Trouble		
6. Diabetes		
7. Other:		

Please explain any problem areas identified above:

Does this child take any medications regularly?	YES	NO
<p>If yes, what medication? _____</p> <p>Reason for medication? _____</p> <p>Dose of medication: _____</p>		

Note to parents: If your child will need to take medication (prescription **OR non-prescription**)

AT SCHOOL, please have your Doctor fill out the Medication Authorization form.

This child should have the following restrictions placed on physical activities:

- None** **See Below**

Other Recommendations:

- None** **See Below**

VISION SCREENING

Results for

Both eyes: _____

Right eye: _____

Left eye: _____

Does this child wear glasses? **Y** **N**

Does this child have other eye problems? **Y** **N**

If yes, please explain:

Physician's Signature: _____ *Date:* _____

Address and Phone Number of Examining Physician:

DENTAL SCREENING

Findings:

Recommendations:

Dentist's Signature: _____ *Date:* _____

Address and Phone Number of Examining Dentist:
