Santa Fe Trail USD #434

Student Health Assessment Form

STUDENT NAME:
(one student per form)

Date of Birth:

Grade:

PARENT PLEASE COMPLETE THE FOLLOWING

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND EMERGENCIES:

☐ NONE

ALLERGIES TO FOOD AND OR MEDICATION (PLEASE LIST REACTION):

☐ NONE

CURRENT PRESCRIPTION MEDICATION:

☐ NONE

PHYSICIAN PLEASE COMPLETE THE FOLLOWING

HEIGHT: WEIGHT:

PHYSICAL EXAMINATION:	Normal	Comments if Abnormal
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Neurologic & Developmental		
Hearing & Vision		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care:

☐ NONE

Signature of Licensed Physician or Advanced Practice Registered Nurse

Date:

Printed Name of Individual Singing Above

Phone Number:

Address

Updated 1/2023