STUDENT'S HEALTH APPRAISAL FORM
2018-19 SCHOOL YEAR

Student's Name _____ Grade in 2018-19

PARENT/GUARDIAN'S EVALUATION OF PUPIL'S HEALTH

Please answer the following questions about your son or daughter:

1. Is your child subject to any condition which may result in a classroom emergency? ☐ Yes ☐ No
   a. Allergic reaction? ☐ Yes ☐ No If Yes, to what? _____
   b. Asthma? ☐ Yes ☐ No
   c. Epilepsy? ☐ Yes ☐ No If Yes, which medication _____
   d. Diabetes? ☐ Yes ☐ No
   e. Heart condition? ☐ Yes ☐ No If Yes, please describe _____
2. At present, is your child under the care of a doctor for a particular illness or on any medication? ☐ Yes ☐ No
   If yes, please state illness and/or medication _____
3. Does your child wear glasses? ☐ Yes ☐ No Contact lenses? ☐ Yes ☐ No How long? _____
   When were glasses/contact lenses last changed? _____
4. Does your child have a hearing loss at the present time? ☐ Yes ☐ No
5. Has your child had any ear infections during the past year? ☐ Yes ☐ No
6. Has your child ever had a severe injury that could affect his/her school participation? ☐ Yes ☐ No
   If yes, please explain _____
7. Has your child ever had any major operations? ☐ Yes ☐ No
   If yes, please explain _____
8. Are there any mental or emotional problems that could affect his/her participation in school? ☐ Yes ☐ No
   If yes, please explain _____
9. Has your child had a dental examination in the past year? ☐ Yes ☐ No
10. Has your son/daughter had a physical examination in the past year? ☐ Yes ☐ No
11. Does your child have a speech problem? ☐ Yes ☐ No
    If yes, please explain _____
12. Is your recommendation for physical activity ☐ Unrestricted ☐ Restricted
    If restricted, please explain _____
13. Other comments concerning health

_____

_____ _____

Parent/Guardian Signature **Date**