School Age Parent Health Assessment Form

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Child's Full Name Birth Date

____

Child's Full Name Birth Date

Any significant Health concerns: **Yes or No**

Any health related needs of child (allergies, medications, injuries):
Yes or No

If yes, please explain: ____
____

Check all that apply for your child:

_____ Vision deficit _____Hearing impairment ___Speech concerns

Does your child have any condition limiting him/her in physical play:
Yes or NO

If yes, please explain: ____
____

Is your child subject to any mental or physical condition which he/she should remain under periodic medical observation? **Yes or No**

If yes, Please explain: ____
____

Any other information you would like to share:
____
____
____
____

Parent Signature: ______________________ Date: _________________

Please attach immunization records