MARTIN LUTHER SCHOOL 2020-2021
STUDENT HEALTH ASSESSMENT SURVEY

THIS FORM IS REQUIRED TO BE COMPLETED AND RETURNED TO THE SCHOOL OR NURSE'S OFFICE

(PLEASE PRINT)

STUDENT NAME (LAST) _____ (FIRST) _____ (MI)_____
DATE OF BIRTH _____ AGE _____ GRADE _____

PARENTS/GUARDIANS:
DAD _____(LAST) _____(FIRST)_____
LIVES IN HOME WITH CHILD? Y N
MOM _____(LAST) _____(FIRST) _____
LIVES IN HOME WITH CHILD? Y N
GUARDIAN OR OTHER? NAME/S _____ _____
RELATIONSHIP: STEP PARENT, GRANDPARENT/GUARDIAN OR OTHER
_____

CONTACT #'S: # 1 NAME _____ # _____
CONTACT # 2 NAME _____ # _____
CONTACT # 3 NAME _____ # _____
IN CASE OF EMERGENCY CALL? _____

NUMBER OF PEOPLE RESIDING IN HOME:
 # ADULTS _____ Relationship to student _____
 # CHILDREN _____ AGES AND GENDER _____
IMMUNIZATIONS UP TO DATE _____
HEALTH CONCERNS: ALLERGIES: FOOD: _____
SYMPTOMS OF EXPOSURE?: _____
TREATMENT REQUIRED? : _____
********MEDICATION TREATMENT FORM COMPLETED? Y ___ N____**
ALLERGIES TO MEDICINES/ ENVIRONMENT?: _____
SYMPTOMS OF EXPOSURE? _____
TREATMENT REQUIRED: _____
*******MEDICATION TREATMENT FORM COMPLETED? Y _____ N _____**
(PLEASE FILE A TREATMENT PLAN/MEDICATION FORM WITH THE SCHOOL IF ANY OF THE ABOVE ARE PRESENT).

STUDENT HEALTH HISTORY:

DIZZINESS Y N DENTAL PROBLEMS Y N
FAINTING Y N ORTHODONTICS Y N (PROVIDER?)
HEADACHES Y N VISION PROBLEMS Y N GLASSES/ CONTACTS
PROVIDER _____ DATE OF LAST EXAM?
_____

ASTHMA YES NO (ACTION PLAN COMPLETED/AVAILABLE ?

IF MEDICATION REQUIRED- APPROPRIATE FORMS COMPLETED? YES _____ NO _____

HYPO OR HYPERGLYCEMIA Yes __ No ___ Action plan completed?

HEART OR LUNG CONDITIONS Yes ___ No __

INTOLERANCE TO HEAT OR COLD Yes ___ N _____

_____

SKIN CONDITIONS OR REACTIONS Yes: No:

SUN SCREEN PRODUCTS REQUIRE AN OVER THE COUNTER MEDICATION FORM FILLED OUT AND THE PRODUCT NEEDS TO BE LEFT WITH THE TEACHER.

SEIZURES OR CONVULSIONS Y N _____

(ACTION PLAN ON FILE AT SCHOOL- ON ANY MEDICATIONS? Y N).

WALKING/GAIT OR JOINT PROBLEMS Y N

STOMACH, BOWEL OR BLADDER PROBLEMS? Y N

GLUTEN OF DIGESTIVE PROBLEMS Y N

HISTORY OF THYROID, BLOOD CLOTTING OR OTHER DISORDERS Y N

MUSCLE PROBLEMS, WEAKNESS TINGLING IN HANDS OR FEET? Y N

LONG TERM SEPARATION FROM ONE OR BOTH PARENTS: Y ___ N _____

REGULAR PHYSICALS AND CHECKUPS WITH MEDICAL PERSONNEL? Y N

FULL TERM PREGNANCY AND UNEVENTFUL DELIVERY? Y N (CONT. ON BACK).

PLEASE LIST ANY REGULAR MEDICATIONS GIVEN, PRESCRIPTION OR OVER THE COUNTER GIVEN ON A REGULAR BASIS AT HOME? (MUST HAVE AN ADMINISTRATION FORM SIGNED AND FILED AT THE SCHOOL)

ANY OTHER PERTINENT MEDICAL/ SOCIAL HISTORY: CONTINUE ON BACK

EMOTIONAL/BEHAVIOR PROBLEMS? Yes No

FEEL FREE TO ATTACH ANY OTHER INFORMATION PERTINENT TO YOUR CHILD'S HISTORY.

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