LAKE SHORE CENTRAL SCHOOLS
STUDENT HEALTH APPRAISAL
(Pre K – 12)

Student's Name______________________________________ M___ F___ Grade ___

Birthdate_____________________ School Building_______________________________

1. Check any of the following conditions that may pertain to your child

__ Asthma

__ Bleeding disorder

__ Birth Defect

__ Diabetes

__ Epilepsy (seizure)

__ Eye condition (glasses or contacts)

__ Gastrointestinal Problems

___ Heart Condition

__ Hospitalization

__ Orthopedic condition

__ Pneumonia

__ Rheumatic fever

__ Scarlet fever

__ Surgery

___ Urinary Problems

PLEASE EXPLAIN ANY (ALL) CONDITION (S) CHECKED

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____

2. Does your child take any medication? YES _________ NO _________

If yes, please list: ____

____

CONTINUED ON BACK SIDE OF THIS FORM

3. Allergy (Please check any of the following that pertains to your child.)

____ Seasonal allergies

____ Insect allergy (type____________________)

____ Food (specify _________________________)

____ Latex

____ Other (specify __________________________)

List any medication needed / taken for allergic condition:

____

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____

4. Has your child had a physical in past year? YES _____ NO _____

FILL OUT THE NECESSARY INFORMATION LISTED BELOW
(PLEASE PRINT)

PHYSICIAN NAME: ____

PHYSICIAN TELEPHONE NUMBER: ________________________________

PREFERRED HOSPTIAL: ____

Parent / Guardian Signature:_________________________________ Date: ______________

Relationship to child: ____