HEALTH SCREENING FORM
For EC Evaluations

Student: _____ DOB: _____

School: _____ Grade: _____ Teacher: _____

1. **Serious Health Condition/Illness (Describe):** Date/Onset Hospitalized

_____ _____ Yes☐ No☐

2. **Accidents (Describe):** Date Hospitalized

_____ _____ Yes☐ No☐

3. **Is this student on any medication taken daily?** Yes☐ No☐
If yes: Name/Dosage of Medication _____
Reason for Medication _____

4. **Is student sick often?** Yes☐ No☐
If yes, why? _____
Does this student appear to be in good health? (Teacher Observation) Yes☐ No☐

5. **Date of student's last visit to the doctor:** _____ **Reason:** _____
Name of student's physician: _____ Dentist: _____
Does this student have health insurance? _____

6. **Important Medical History** (Circle and explain those that apply)

Allergies (medicine, food, bee/wasp sting): _____
What happens? _____ Epi-pen prescribed by doctor: _____

☐**Asthma**…Date of last attack _____ …Medication needed _____

☐**Diabetes** (Type 1 or Type 2) _____ Insulin dependent? _____ Oral medication? _____

☐**Seizures**…Date of last seizure _____ …Medication needed _____

☐**Arthritis** ☐**Bleeding Problem** ☐**Hearing Problems (Hearing Aid** _____) ☐**Sickle Cell**

☐**Kidney Problem** ☐**Orthopedic (bone or muscle) Problem** ☐**Heart Problem**

Vision Problem Does he/she wear glasses? _____ … Date of last eye exam: _____

7. **Vision Screen Results:** with/without glasses FAR Rt. 20/_____ Lt. 20/_____
Date: _____ NEAR Rt. 20/_____ Lt. 20/_____
Referred to "eye doctor" _____
Comments: _____

8. **Parents/Guardians names and phone numbers** _____

Source of information: School Records☐ Parent/Student Interview ☐ Dr./Medical Records ☐ Other ☐
Referred by School Nurse to_____

Signature/Title of Person Completing Form Date