Child's Name _____Sex____Date of Birth _____

NICE Community Schools Health Appraisal Form

Health History		
Is your child having any of the problems listed below?	Yes	No
1. Allergies or reactions: (examples, food, medication, or other)		
2. Asthma, hay fever, or wheezing		
3. Eczema or frequent skin rashes		
4. Convulsions / Seizures		
5. Heart condition		
6. Diabetes		
7. Frequent colds, infections, sore throats, earaches (>4 / year)		
8. Trouble passing urine or bowel movements		
9. Shortness of breath		
10. Speech problems		
11. Menstrual Problems (if applicable)		
12. Dental problems. Date of last examination		
13. Has your child had chickenpox?		
14. Surgeries or hospitalizations		
15. Hearing or Vision Problems		
16. Epilepsy, diabetes, fainting (anything to cause emergencies)		
16. Other		
Please explain any problem areas identified above:		

Does your child take any medication regularly? Yes_____ No_____
If yes, what medication_____
Reason for medication_____
Time medication is to be given _____

If your child has a health concern that would require there to be special accommodations made while they are here in school please contact the building principal or the school nurse to arrange a meeting to establish a 504 plan.

IMMUNIZATIONS MUST BE UP TO DATE FOR SCHOOL ATTENDANCE.

Parent's Signature_____Date_____