

**GCISD HEALTH ASSESSMENT
KidzU
MUST BE COMPLETED FOR EVERY STUDENT**

Home School _____ Next Grade _____

Student's Name: _____ Girl ___ Boy ___ Age as of June 1 (Years) _____

Home Address: _____ Phone: () _____ Birth Date _____

City: _____ State: _____ Zip: _____

Mother/Guardian Name: _____ Phone: () _____

Father/Guardian Name: _____ Phone: () _____

Student lives with: Both Parents ___ Mother ___ Father ___ Other ___

Persons authorized to pickup and to be contacted in case of emergency when parent/guardian cannot be reached.

1. Name: _____ Relationship _____ Day Phone: () _____

2. Name: _____ Relationship _____ Day Phone: () _____

Health Conditions (check those that apply)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections (chronic/numerous) | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Special Dietary Regimen |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Bone Disease/Fractures | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Heart/Blood Disease | <input type="checkbox"/> Throat Infection |
| <input type="checkbox"/> Contact Lenses/Glasses | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Disease (chronic/numerous) | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent Stomach Aches | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Other (specify below) |

Please explain any conditions that you checked above. Indicate any information useful to the nurse.

Please list any medication your child takes on a routine or frequent basis.

ANY non-prescription medication (including Tylenol) given at school must be accompanied by a physician's order.
Prescription medication must be in original pharmacy container accompanied by parental note.

NOTE: All medications must be administered by KidzU staff, and stored in a secure location.

Allergies:

Describe which foods, medicines, etc. cause allergies and the symptoms exhibited. _____

Are there other factors in the family, which might affect your child's school experience or assist us in serving your child?

I certify that the above information is correct and can be shared with the classroom teacher.

Signature of Parent

Date

AUTHORIZATION FOR EMERGENCY CARE

I know of no health reason(s), other than the information indicated on this form, why my child should not participate in any school activity. I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. If transportation by ambulance is required, this may be obtained.

Name of Physician

Address

() _____
Phone

Name of Dentist

Address

() _____
Phone

Preferred Hospital _____

Signature of Parent

Date