Health Assessment Form

(Form to be kept with students during programming)

Student's Full Name____

Does student have any allergies? ☐ Yes ☐ No

If yes, please indicate (i.e. medicine, latex, food, seasonal):______________________________

____

Students Source of Medical Care/Primary Care

Health Insurance Name: ____

Group/Contract Number______________________ ☐ Copy of card attached.

Physician Name:__________________________ Telephone:______________

Dental Care/Dentist Name:___________________ Telephone:______________

EMERGENCY CONTACTS	Relationship	Contact Name	Telephone Number During Program Time	Other Telephone Number (check type)
				☐ Pager ☐ Cell ☐ Other
				☐ Pager ☐ Cell ☐ Other
				☐ Pager ☐ Cell ☐ Other
				☐ Pager ☐ Cell ☐ Other

Special needs / Concerns / Additional Comments ______________________________

____

____

A Tuberculin Test may be required for certain programs.

A TB Test ☑ is not required ☐ is required.

If required is checked, please provide a copy of test results or use the attached form.

Parent/Guardian Signature______________________________ **Date:**__________