School Entry Health Screening Form

Student Information

Name

Date of Birth

Grade

School Year

Parent/Guardian Information

Name

Phone Number

Address

Email

Health History

Has your child had any of the following? (Check all that apply):

- [ ] Asthma
- [ ] Allergies
- [ ] Diabetes
- [ ] Seizures
- [ ] Heart Condition
- [ ] Other

If other, please specify

Current Medications

Special Needs/Health Concerns

Immunization

Are your child's immunizations up to date?

If no, explain

Screening

Height

Weight

Vision

Hearing

Physician/Clinic Name

Physician/Clinic Phone

Parent/Guardian Signature

Name

Date