



School Age Assessment Health Form and Immunization Declaration

HEALTH STATEMENT

Child's Full Name: _____ Date: _____

Has your child had any significant illness or surgery? Yes No (If yes, please explain.)

Does your child have any special health-related needs such as allergies, injuries or medications that require additional attention? Yes No (If yes, please explain.) _____

PHYSICAL ASSESSMENT

Does your child experience any problems with vision, hearing or speech that we should be aware of, or could compensate for with appropriate action? Yes No (If yes, please explain.) _____

Does your child have a physical condition that might limit his or her classroom activities or physical education? Yes No (If yes, please explain.) _____

Does your child have a physical condition that might result in an emergency situation? Yes No (If yes, please explain.) _____

Does your child have any mental or physical conditions for which he or she should remain under periodic medical observation? Yes No (If yes, please explain.) _____

Is there any other medical information you feel we should know to provide your child with the best possible care?

_____ Parent's Signature	_____ Date
_____ Parent's Signature	_____ Date
_____ Parent's Signature	_____ Date
_____ Parent's Signature	_____ Date
_____ Parent's Signature	_____ Date

For Centers serving school-age children operating in the same facility in which your child attends school: My signature above each year certifies that immunization information for my child has been provided and is available in the school file.