REQUIRED FOR PK3, PK4, KINDERGARTEN AND NEW STUDENTS.

Our Lady of Mount Carmel Parish School
1355 West 70th Street * * Cleveland, Ohio 44102
Telephone: (216) 281-7146 Fax (216) 281-7001

2018-2019 Student Assessment Form

*THIS FORM IS TO BE COMPLETED AND SIGNED BY A PARENT OR LEGAL GUARDIAN.

Child's Name	Date of Birth	Age	Grade

Health Conditions: Please check any of the following health conditions that your child has had:

_____Abnormal spinal curvature
_____Allergies or Hay Fever
_____Lungs
_____Asthma
_____Behavior/Emotional Problems
_____Birth or Congenital Malformations
_____Cancer, Type _____
_____Cystic Fibrosis
_____Diabetes (Type I/Type II)
_____Frequent Throat Infections
_____Abdomen/Hernia
_____Wetting (daytime/nighttime)
_____Urinary Infections (frequent)
_____Ear Infections (frequent)
_____Eczema
_____Concerns with relationships with others
_____Heart Disease
_____Hepatitis
_____Kidney Disease
_____Meningitis/Encephalitis
_____Rheumatic Fever
_____Seizure/Epilepsy
_____Sickle Cell Disease
_____Skin Rashes (frequent)
_____Diarrhea (Chronic)
_____Constipation (chronic)
_____Stool Soiling
_____Tics/Nervous Twitches
_____Headaches
_____P.E. Tubes
_____Anemia
_____Arthritis

Please comment on any of the above that you have checked: _____

_____

Illness and Injures: List any serious illness or injuries

Illness/Injuries	Child's Age	Hospitalized
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comments:_____

_____

Medications:

Are any medications given daily? _____ If yes, what are they?_____
Are any medications given frequently? _____ If yes, what are they?_____

Activity:

Is this child usually: very active _____ normally active _____ inactive_____
Does this child wear glasses? _____ Date of last vision exam _____
Do you have any concerns about how this child interacts with others? _____

_____

Do you have any other comments or concerns about this child's health, development, behavior, family or home life that you would like to share with the school? If yes, please explain:_____

_____

Does your child wear seatbelts in cars? Yes_____ No_____
Date of last physical exam_____Date of last dental exam_____
Completed by: _____Date_____
Relationship to child:_____