ASSUMPTION ACADEMY
WALTON, KENTUCKY

Child Health Assessment

Child's full name:_______________________ Date and place of Birth:_______________________

Home address: ____

Home Phone ____________ Mother's Cell ______________ Father's Cell_______________

Father's name: _______________________________

Mother's full name: ___________________________ (maiden name)_________________

IMMUNIZATIONS: A copy of your child's Kentucky state immunization record and/or notarized KY exemption must be included with this form. No out of state forms or electronic records will be accepted.

HEALTH HISTORY: To be filled out by parent or guardian

1. Are there any chronic illness problems in your family, such as: heart disease, diabetes, cancer, convulsion, or others? Yes No

2. Were there any pre-natal or delivery problems with the child? Yes No

3. Was this child delayed in walking, talking, or speaking? Yes No

4. Does this child:

   a. see a physician regularly for any illness problems? Yes No

   b. have a history of any hospitalization? Yes No

   c. have a problem with being shy or overactive? Yes No

   d. have any emotional problem? Yes No

   e. need any special help in school? If yes, explain. Yes No

   f. have any of the following problems? Yes No

Allergies: Yes/No ______ Earaches: Yes/No ______ Frequent sore throat/colds: Yes/No_______

Headaches: Yes/No _______ Other: Yes/No ______ If yes, please explain: ______________________

____

____

List any childhood diseases or other illnesses your child has had: ______________________

____

Is there any special information that would help the school in caring for your child? ______________

____

Physical Examination for NEW Students

The Academy strongly encourages physicals for returning 6th and 9th grade students. This does form not replace the yearly sports physical form required for team sports - soccer, basketball, and baseball.

To be completed by licensed physician or nurse approved to perform health assessments:

Height: ___________________________________ Weight: ____________________________

Nutritional Status: ____

Current Medications: ____

Allergies: ____

Part Examined or Evaluated	√ if normal	Abnormal/atypical findings (describe)
Head		
EENT		
Teeth		
Heart		
Lungs		
Abdomen		
Genitourinary		
GYN		
Skeletal		
Neurological		
Vision Screening		
Speech Screening		
Hearing Screening		

Immunization Records: Required. Update as necessary.

Do you see this child for regular health supervision? Yes ______ No ______
This child is cleared for all activities associated with school.
□ Yes □ Yes, with restrictions/limitations □ Not cleared
Please describe below any restrictions, limitations, or reasons for "Not cleared" status:

____

____

Signed: ____ Date: __________________________________
Licensed Physician or Nurse approved to perform health assessments