**WESTPORT PUBLIC SCHOOLS**

**[Name of] School**

Health Office – (203) 000-0000

**CONFIDENTIAL HEALTH ASSESSMENT**

**Name:** D**ate of Birth:**

**Grade:**   **Age:**

**Date of Report:**

**Report Completed by:**

**Identification Statement:**

**Prior Medical History:**

1. **Gestational Prenatal and Birth History**
2. **Neonatal/ Infancy**
3. **Past Medical History**

**Family History:**

1. **Medical**

**Current Health Status:**

**Physicians/Health Maintenance:**

**Allergies:**

**Medications:**

**Vision:**

**Hearing:**

**Summary of Health Needs at School/Medical Impact on Educational Performance**

Submitted by:

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 School Nurse Date