



## AST Health Form

<b>Applicant:</b>	<b>Grade:</b>	<b>Date:</b>
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1. Does your child have allergies? Yes \_\_\_ (please explain) No \_\_\_

Asthma _____	Pollen _____	Insects _____
Food _____ (for example: nuts, shellfish, dairy, wheat, etc.)		
Describe Reaction: _____		
Treatment/Medication required: _____		
_____		

2. Are there any concerns regarding: Vision Yes \_\_\_ No \_\_\_  
Hearing Yes \_\_\_ No \_\_\_  
Speech Yes \_\_\_ (please explain) No \_\_\_  
*Does your child wear eyeglasses?* Yes \_\_\_ No \_\_\_

3. Has your child ever been hospitalized or had surgery? Yes \_\_\_ (please explain) No \_\_\_

4. Has your child ever been diagnosed with a learning challenge or disability? Yes \_\_\_ (please describe) No \_\_\_

