Teacher's Observation of Child Health

Child's Name _____ Teacher _____

Classroom_____ **Date of Observation 1st** _____ **2nd** _____

Staff initials verify that the parent has been notified (a copy sent home) results within 10 days of the date completed. ☐

Does this child complain of or demonstrate any of the following more severely or more often than most of his/her classmates?

	1		2	
	Y	N	Y	N
Tires Easily				
Frequently Sleepy				
Inactive				
Shortness of Breath with Exercise				
Unintelligible Speech				
Hearing Difficulties				
Discharge or Drainage from Ears				
Continuous Runny Nose				
Frequent Nose Picking or Rubbing				
Seizures or Spells				
Mouth or Tooth Pain				
Headaches				
Clumsiness				
Poor Vision				
Eyes Cross or Turn Out				

	1		2	
	Y	N	Y	N
Poor Posture, Limp / Abnormal Gait				
Poor Nutrition or Eating Habits				
Poor Hygiene				
Skin Rash / Skin Sores				
Frequent Scratching				
Pale or Sallow Skin				
Red, Runny or Itchy Eyes				
Stomachaches				
Vomiting				
Frequent Urination				
Wet Pants				
Soil Self with Bowel Movements				
Coughing				
Wheezing				
Diarrhea				

What is your opinion of this child's Health?

Perfectly Healthy ☐ **Specific Problem(s) as noted but Generally Healthy** ☐

Not in Good Health ☐

It is required that you document how you are addressing any item(s) marked YES.

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