

STUDENT HEALTH QUESTIONNAIRE

Student's Name _____ Grade _____

1) Has your child had any serious illnesses, accidents, or hospitalizations in the last year?

Yes, Please Explain _____

No

2) Is there any chronic condition or disease that I should be aware of that may limit your child's activities?

Yes, Please Explain _____

No

3) Does your child have any allergies (animals, medicine, food, etc.)

Yes, Please Explain _____

No

4) Does your child take any medications at home that may affect them at school?

Yes, Please list _____

No

5) Will your child take medicine at school?

Yes, Please list _____

What are they for? _____

No

6) May we share this information with appropriate staff? (Teachers, Paras, Bus Drivers, Coaches, Office Personnel, Cafeteria Staff, Playground Supervisors)

Yes

No

EMERGENCY INFORMATION

Family Doctor _____

Preferred Hospital _____

Please note that school policy requires that we must have a signed form from a Physician for ALL prescription medications administered at school. Non-prescription medications (including cough drops) require a signed form from a parent. All medications should be brought by a parent in its original container.

PARENT'S SIGNATURE _____ DATE _____