STUDENT HEALTH QUESTIONAIRE

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, ect.)
___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, Aides, Bus Drivers, Coaches, Office Personnel, Cafeteria Staff, Playground Supervisors)
___Yes
___No

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 _____