



Student Health Questionnaire

The following information is requested by the school nurse to plan an appropriate program for your child's needs in school, should any emergency situation arise. We would appreciate your completion of this form. Please note that:

- **Parent/Guardian is responsible for providing the school with any medication, or equipment that the student will require during the school day.**
- **If an individual school health care plan is indicated, Parent/Guardian is responsible for providing the school health nurse with the necessary medical information.**

Please check with the school's front office to obtain the correct medication and procedure forms.

Part 1. Parent/Guardian to complete during the registration process.

Student Information

Student's Name (Last):	Student's Name (First):	Middle initial:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
School:		Grade:	Teacher's Name:	

Parent Information

Parent/Guardian's Name:		Relationship to student:	Parent/Guardian Name:	Relationship to student:	
Home phone #:	Cell phone #:	Work phone #:	Home phone #:	Cell Phone #:	Work phone #:
Emergency Contact Name:		Phone #:	Emergency Contact Name:		Phone #:

My Child has a medical condition that may affect his or her school day. No Yes (If yes, continue to part 2.)

Parent/Guardian Name (print)

Parent/Guardian Signature

Date

Attention school staff; please return this form to the school nurse if parent checked "yes" above.

Part 2. Medical Information (Complete all boxes that apply to your child)

A. Medical History

<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Seizures	<input type="checkbox"/> Bladder/Kidney problems	<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Vision problems	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Orthopedic problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other (please specify): _____	

Does your child have a primary care physician? <input type="checkbox"/> No <input type="checkbox"/> Yes	Name of physician:	Physician's phone #:	Date of last appointment:
---	--------------------	----------------------	---------------------------

Does your child see a specialist? <input type="checkbox"/> No <input type="checkbox"/> Yes	Name of specialist:	Specialist's phone #:	Date of last appointment:
--	---------------------	-----------------------	---------------------------

Does your child require activity restrictions? No Yes, (If yes, school must have medical documentation from a physician on file to accommodate any restrictions.)

B. Medications: Please list all medications your child takes on a daily or as needed basis (use additional paper if more space is needed.)

Medication Name	How much	Time given	Side Effects

Continue on reverse

C. Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes (If allergies are severe, please provide an allergy action plan from your child's physician.)		
*Are the allergies: <input type="checkbox"/> Mild <input type="checkbox"/> Severe	What is your child allergic to? (Check all that apply)	Please Specify:
Date of Last Severe Reaction: ____/____/____	<input type="checkbox"/> Foods:	
Allergy caused by: <input type="checkbox"/> Ingestion <input type="checkbox"/> inhalation <input type="checkbox"/> contact	<input type="checkbox"/> Insect Stings/Bites:	
	<input type="checkbox"/> Medication:	
	<input type="checkbox"/> Plants/Environmental: <input type="checkbox"/> Unknown	
Does your child have a food intolerance? If yes, please specify: _____		
Please check all symptoms noted with allergic reaction:		
<input type="checkbox"/> Redness	<input type="checkbox"/> Severe swelling	<input type="checkbox"/> Itching
<input type="checkbox"/> Breathing problems	<input type="checkbox"/> Swelling of lips/face	<input type="checkbox"/> Loss of consciousness
<input type="checkbox"/> Hives		
<input type="checkbox"/> Nausea		
If your child has a reaction, what do you do to treat the symptoms? _____		
*Please list all medications your child takes for allergies in section B.		
Has your child been prescribed an epinephrine auto-injector to be used in an emergency? <input type="checkbox"/> No <input type="checkbox"/> Yes		
*It is recommended that an epinephrine auto-injector be provided to the school if the student has had a severe reaction in the past.		

D. Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please provide an asthma action plan from your child's physician.)		
Has your child ever been hospitalized due to asthma? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when was last hospitalization? _____		
What symptoms does your child experience during an asthma episode?		
<input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Coughing <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest Pain/Discomfort <input type="checkbox"/> Other: _____		
What triggers your child's asthma?: (check all that apply)		
Trigger:	Please specify/explain:	Currently prescribed medications: <input type="checkbox"/> Inhaler (rescue) <input type="checkbox"/> Inhaler (controller) <input type="checkbox"/> Nebulizer <input type="checkbox"/> Oral steroids <input type="checkbox"/> Oral antihistamines *Please list all medications in section B. *It is recommended that an inhaler be provided to the school if the student has asthma.
<input type="checkbox"/> Exercise		
<input type="checkbox"/> Environmental		
<input type="checkbox"/> Foods		
<input type="checkbox"/> Unknown		
<input type="checkbox"/> Other		

E. Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please provide a current Diabetes Medical Management Plan from your child's physician.)	
Currently prescribed medications and treatments (check all that apply and list medications in section B.)	
Insulin via: <input type="checkbox"/> Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Pump	
<input type="checkbox"/> Blood sugar testing <input type="checkbox"/> Glucagon <input type="checkbox"/> Oral Medications <input type="checkbox"/> Continuous glucose monitoring	
*It is recommended that a complete set of diabetic supplies (insulin, glucagon, fast acting sugar, protein snack, glucometer, etc.) be provided to the school for a student with diabetes even if the student has permission to self-carry these items.	
What symptoms does your child exhibit with low blood sugar?	What symptoms does your child exhibit with high blood sugar?
Does your child recognize the symptoms of a low blood sugar? <input type="checkbox"/> No <input type="checkbox"/> Yes	Does your child recognize the symptoms of a high blood sugar? <input type="checkbox"/> No <input type="checkbox"/> Yes

F. Seizure Disorder <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please provide a seizure action plan from your child's physician.)			
Type of Seizure: <input type="checkbox"/> Convulsive <input type="checkbox"/> Non-Convulsive	What symptoms does your child have when having a seizure?		
Date of last seizure:	Length of seizure:	Known triggers:	Has diastat or other emergency seizure medication been prescribed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medications: Please list all medication student takes for seizures in section B.			
Are any physical activity restrictions required? <input type="checkbox"/> No <input type="checkbox"/> Yes			
*If yes, school must have medical documentation from a physician on file to accommodate any restrictions.			