HEALTH HISTORY QUESTIONNAIRE

Student Name: Last, First, Middle	Date of Birth:	Sex:	Race:	School and Grade:

Parent/Guardian Names:	Address:

Home Phone:	Work Phone – Father	Work Phone – Mother

Family Physician:	Phone Number:
Family Dentist:	Phone Number:

Please check if your child has any of the following:

__ ASTHMA If yes, does your child need to use an inhaler during school? _____
What triggers asthma attacks? _____
What symptoms does your child exhibit when an attack begins?_____
Special Instructions: _____

__DIABETES: If yes, does your child require insulin during school time? _____
Does your child require blood sugar checks during school time? _____
Special Instructions: _____

__SEIZURE DISORDER: If yes, what type of seizure does your child have?_____
(Example: Grand mal, petit mal, or silent seizures, history of febrile seizures)
How often does your child have seizures? _____
Special Instructions: _____

__HEART PROBLEMS: If yes, describe type of problem that might need attention during school time: _____

__KIDNEY, BOWEL, OR BLADDER PROBLEMS: Describe type of problem that may need attention during school hours: _____

__NUTRITIONAL PROBLEMS: Describe: _____

__PHYSICAL DISABILITY OR LIMITATIONS: Describe: _____

__VISION OR HEARING PROBLEMS: Describe: _____

__ATTENTION DEFICIT: Is medication required during school hours? _____

ALLERGIES:

__FOOD: List type of food and reaction: _____
__BEE STINGS/INSECT BITES: Describe symptoms of reaction: _____
__ENVIRONMENTAL ALLERGIES: List allergens and symptoms of reaction:
_____

Do you desire Benadryl to be given for allergic reaction? _____
Does your child require Bee Sting Kit or EPI-PEN for severe reactions? _____

OTHER HEALTH PROBLEMS/CONCERNS/SPECIAL INSTRUCTIONS:
_____
_____

MEDICATION INFORMATION

List any medications your child needs regularly or intermittently (such as Tylenol, Benadryl) at school and indicate the reason:

Medication: _____Time to be taken:_____Reason:_____

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For these medications to be given at school, we must have a completed physician's medication order form on file. The medication must be sent to school in the original pharmacy container. Medications such as Tylenol, Benadryl, etc., are not kept on hand at school and need to be sent in by the parent along with a consent form for the student to be given the non-prescription medication.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

OFFICE USE:

___New Student – Preschool Enrollment
___New Student – Kindergarten Enrollment
___New Student – Transfer in State
___New Student – Transfer out of State
___New Student – Re-entry