RSU #1

Health Questionnaire

(To be filled out by parent/guardian each school year)

Student's Name _____ Date of Birth _____Grade/Teacher _____
Mother/Guardian _____ Phone(s)_____
Father/Guardian_____ Phone(s)_____
Primary Physician _____ Date of Last Physical Exam _____
Dentist _____ Date of Last Dental Exam _____
Outside/In Home Counselor _____

PLEASE CIRCLE ALL THAT APPLIES TO YOUR CHILD:

Allergies (submit allergy action plan)	ADD/ADHD	Cystic Fibrosis
Diabetes	Heart Condition	Frequent Headaches/Migraine
Seizure Disorder	Mental Health Issues	Recent Serious Illness/Injury
Asthma (submit asthma plan)	Hospitalizations/Surgery	

Special Diet Restrictions (submit doctor's order)

Please explain any situations or conditions circled above including any other chronic health concerns not listed:

_____

_____

Asthma? Yes ___ No ___ Will an inhaler need to be available during school hours? Yes ___ No ___
If yes to either question, please explain. _____
If your child may need to use an inhaler during school hours, an asthma plan and inhaler must be submitted to the school nurse.

Allergies (food, medication, environmental or insect stings): _____
Is an Epi-Pen used? Yes ___ No ___ Is Benadryl used? Yes ___ No ___
If Yes to either question, please explain and submit required medicine and an allergy action plan to the school nurse.

_____

List all medications not previously mentioned, with dose and frequency, taken by your child:
At Home _____
At School _____

If medications must be given during school hours, you and your doctor must complete and sign our school medication form before medications will be dispensed to your child. All medications must be kept in their original bottle and stored in the clinic. Special arrangements may be made for inhalers and other emergency medications. Please discuss with the school nurse.

Does your child have health insurance? Yes ___ No ___ Name of Insurance:_____
Does student wear glasses? Yes __ No __Contact lenses? Yes ___ No ___ Date of last exam:_____
Does student have history of hearing problems? Yes ___ No ___ Wear hearing aids? Yes ___ No ___

Is your child able to participate in a full school physical education program and/or sport program? Yes ___ No ___
If no, please explain. _____

Are there any family situations that may affect your child that we should be aware of (illness, divorce, deployment)?

_____

_____

_____ _____
Signature of Parent/Guardian Date