HEALTH QUESTIONNAIRE

Dear Parent(s) –

To best be informed of your child's health status, I would like to collect some current health information. Please complete this form and return it to the school health office before school starts this fall. If your student needs to take medication during school hours (prescription or over-the counter), a **"Consent for Administration of Medication"** must be signed and returned to the school health office. Thanks for your cooperation!

Sincerely,

Jill Davis, RN, PHN
School Nurse

Student's Name: **Date of Birth:**

Parent's Name: **Grade/Teacher:**

Mailing Address: **Physician/Clinic:**

Phone Number(s):

Health History

(Please give details if your student has any problems in the areas listed below.)

Allergies –

Asthma/Lungs –

Endocrine/Hormonal (i.e. diabetes, growth disorders) –

Musculoskeletal/Orthopedic (bones, muscles) –

Circulatory (i.e. heart, blood) –

Bowel/Bladder –

Neurological (i.e. seizures, paralysis) –

Hearing/Vision –

Surgeries –

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In the best interest of my child, I give permission to share this information with appropriate school staff in providing a safe, healthy environment for my student while at school.

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Parent/Guardian Signature ***Date***