WAYNESBORO PUBLIC SCHOOLS
HEALTH QUESTIONNAIRE

Student Name________________________________ **Grade**_______ **Date**________________________

School____**Teacher** ________________________

You have indicated on your child's emergency card that he/she has a health concern. To help meet your child's medical needs in the school setting, please complete the following health questionnaire and return it to your child's school nurse as soon as possible.

PLEASE CHECK ALL THAT APPLIES OF YOUR CHILD

☐ADD/ADHD ☐Heart Condition ☐Asthma ☐Frequent Headaches/Migraines

☐Seizure Disorder ☐Vision Problem ☐Hearing loss ☐Stomach/Colon problems

☐Diabetes ☐Bone/Joint problems ☐Muscle problems ☐Psychiatric/Emotional problems

☐Other chronic health concerns (specify) ____

Please provide details of the conditions/concerns marked above ____

____

☐ **Allergies** (food, medication, environment, insects) Explain____

Epi-Pen used? Yes _______ No ________ Benadryl used? Yes _______ No _______

(If you answer yes, then the **Medication Administration/Permission Form** must be completed)

IN THE **<u>PAST YEAR</u>** HAS YOUR CHILD ... (Please explain all yes responses below)

had any serious illness? Yes ________ No _________

had any serious injuries? Yes ________ No _________

had mental health problems? Yes ________ No _________

been hospitalized? Yes ________ No _________

had surgery? Yes ________ No _________

Comments____

LIST ALL MEDICATION, WITH DOSE, TAKEN BY YOUR CHILD

At Home ____

At School ____

Does student wear glasses? Yes ________ No _________

Does student wear contact lenses? Yes ________ No _________

Does student wear hearing aids? Yes ________ No _________

Does student have a history of hearing problems? Yes ________ No _________

Do you have any concerns about your child's eating habits? Yes ________ No _________

Do you have any concerns about your child's sleep pattern? Yes ________ No _________

Does your child have any physical restrictions? Yes ________ No _________

Are there any restrictions with your child's activity at school? Yes ________ No _________

If yes, please describe:____

____

Upon reviewing this information, it will be determined if your child requires an "Individual Health Care Plan" for the school setting. If needed, a form will be sent home for you to have your physician fill out and return.

_______________________________________ _______________________________________

Signature of Parent/Guardian Reviewed by: School Nurse Signature

(Health Questionnaire)