

Dear Parent/Guardian:

Each year the school district nurses and the health office staff prepare a Confidential Health Concern List that alerts the school staff to students with health needs, such as asthma, diabetes, seizures. Please assist us by completing this questionnaire as soon as possible and return it to the District Office along with completed enrollment forms. The school district nurses will review this information and contact you if more information is needed. PLEASE RETURN THIS QUESTIONNAIRE EVEN IF YOUR CHILD HAS NO HEALTH CONCERNS AT THIS TIME. If you would like to speak directly to a nurse, please call 835-4109.

Child's Name: _____ **Date of Birth:** _____

Parent/Guardian Name(s): _____

Address: _____ **Phone#:** _____

_____ **School (if known):** _____

**** If you need more space please write on the back of this sheet. ****

Does your child have any of the following conditions?

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	To What:	_____	
Vision Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain:	_____	
Hearing Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain:	_____	
Physical Disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain:	_____	

Has your child ever had a serious injury? Yes No
If yes, please explain: _____

Has your child ever been hospitalized? Yes No
If yes, please explain: _____

Does your child have any health concerns not listed above? Yes No
If yes, please explain: _____

Does your child have any physical limitations? Yes No
If yes, please explain: _____

In case of emergency or illness and parent/guardian cannot be reached, does the school have permission to seek medical attention? Yes No
If no, what do parents/guardian want done? _____

Is this student under medical supervision and/or on medication? Yes No
Please indicate which medication(s) the student is taking and whether the medication is needed during school hours:

NOTE: If child is taking prescribed medication while at school, there must be a parent and physician signed medication form on file in the health office where student attends school.

Does the health staff have your permission to share your child's health information with staff? Yes No

Date of last Physical exam: _____ Date of last Dental exam: _____

Parent/Guardian Signature: _____ **Date:** _____