Enrollment for School Year: 20____ - 20____

Annual Student Health Survey

(Last)_____(First)_____(Middle)_____(Nickname)_____

Student's Legal Name

Gender: ☐Male ☐Female Date of Birth: ___/___/___ Grade _____

Please circle any of the following conditions that affect your child, and use the space provided to give additional information you feel would be helpful in the care of your child:

YES NO ADD/ADHD – Medication_____

YES NO Allergies (Specify)_____

(Medication)_____

YES NO Anxiety – Medication_____

YES NO Asthma – Medication_____

YES NO Autism/Asperger's Spectrum – Medication_____

YES NO Cancer_____

YES NO Depression – Medication_____

YES NO Diabetes – Medication_____

YES NO Heart/Lung Problems_____

YES NO Hearing Concerns/Ear Infections_____

YES NO Kidney/Bladder Problems_____

YES NO Major Illness/Injury – Specify_____

YES NO Orthopedic Issues_____

YES NO Seizures – Medication_____

YES NO Stomach/Bowel Problems_____

YES NO Surgery_____

YES NO Vision (Glasses/Contacts/Others)_____

Other than listed above, is your child currently taking any medication on a regular basis (prescription or over the counter)? If yes, what kind of medication and what is the reason for taking it? _____Dosage_____

Is your child currently under any kind of on-going medical treatment or care?_____

Will your child need Medical/Nursing care at school? If yes, please describe in detail.

_____

Please note that serious, life threatening health concerns will need a health care plan. Please contact your school nurse as soon as possible to schedule an appointment to complete this information.

(PLEASE TURN OVER)

Physician	Phone Number
Specialist	Phone Number
Dentist	Phone Number

Additional Comments: