SUSQUEHANNA TOWNSHIP SCHOOL DISTRICT

2579 INTERSTATE DRIVE HARRISBURG, PENNSYLVANIA 17110

Annual Health Questionnaire

Student's Name: _____ Grade: _____ Room: _____

Parent/Guardian: _____ Phone: _____

During the past five years, has your child been under a health care provider's care for any of the following chronic conditions (please circle and provide health care provider documentation and instruction):

asthma	diabetes	sickle cell disease	cystic fibrosis
life threatening allergy	seizure disorder	spina bifida	
arthritis	ADD/ADHD	Tourette's syndrome	
heart condition	bleeding disorder	Cerebral palsy	

Comments: _____
_____

During the past year has your child had concerns in any of the following areas (please circle)?

non-life threatening allergy	vision/hearing	respiratory (non-asthma)	stomach/bowel
serious injury	social/emotional	muscular/skeletal	food intolerance
surgery	psychiatric	kidney/bladder	other

Comments: _____
_____

Please list any life threatening allergies and reaction:
_____
_____

Please list non-life threatening allergies and reaction:
_____
_____

Please list any food intolerances or religious/philosophical preferences (lactose intolerance, no meat):
_____
_____

Please list any medications or treatments that your child currently requires:
_____
_____

Does your child require any medications or treatments to be provided while at school? **YES** **NO**

If the above answer is "yes" we MUST receive health care provider orders and written parent permission every year prior to the medications or treatments being administered at school.

Health Care Provider Name: _____ Phone: _____ Last Visit: _____

Dental Care Provider Name: _____ Phone: _____ Last visit: _____

The information provided above is to the best of my knowledge. I understand that if any of the above information changes, it is my responsibility to notify the school nurse of those changes as soon as possible.

Signature_____ Date:_____