MEDICAL SURVEY

Child's Last Name _____

Child's First Name _____

Grade _____

Dear Parents,
Please take a moment to complete the following survey. I will need to reference it throughout the school year in the event that your child should have any injuries or health needs while at school. Please complete one survey per child. Feel free to contact me if you would like to discuss any medical issues or concerns.

Reminder: In addition to this Medical Survey, reports of Physical Exams are required to be submitted in KS, 6th grade and 11th grade. Also, reports of Dental Exams are required to be submitted in K5. 3rd grade & 7th grade. There are forms available in the school office to be completed by-your physician and dentist. If you would like to submit exam reports in addition to the scheduled years, I'll be happy to keep them in your child's School Health file. Thank you.

*If you answer yes to any of the following, please explain in the comments section.
Please list any additional health concerns and /or information:

In the past has your child experienced, do they have or are they presently:	No	Yes*	Comments
1. Any serious illness, injury or surgery			
2. Being treated for asthma, seizures, heart murmur, etc.			
3. Restrictions in physical education			
4. Allergies to medication, foods, insect bites or pollutants.			
5. Taking any medication, or inhalers, daily or as needed. Please list the name, dosage, time taken, and reason for medication.			
6. In the past year has your child received any immunizations?			

(Please check all appropriate boxes.)
I give my permission for my child to be treated with or be given the following as needed:

	Tylenol		Ibuprofen ie: Motrin, Advil
	Cough Drops		Antacid -Tums, Mylanta
	Cough Syrup -Tussin, Tussin DM, Tussin CF		Triple Antibiotic cream to be used on cuts
	Benadryl - for signs of allergic reaction		Would you like to be notified when your child is treated with medications? Please circle your preference:
	Bismuth Tablets (Pepto-Bismul)		
	Other:		Phone Note

Parent's Name _____ Daytime Phone Number _____

Emergency Contact Person _____ Phone Number _____

Parent's Signature _____ Date _____

If your child is treated in the nurse's office at school during the school day, you will receive an emailed Nurse Visit Report with details.