# Annual Student Health Survey

Enrollment for School Year: 20____- 20____

**(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 (if your child requires medication to be taken at school, please see the school nurse for required documentation):*

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)_____

1) 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_____
2) Is your child currently under any kind of on-going medical treatment or care?_____
3) 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. Additional Comments (please feel free to use the back of this form):**

_____ _____

Physician Phone Number

_____ _____

Specialist Phone Number

_____ _____

Dentist Phone Number

Parent Signature: _____ Date: _____