Student Enrollment Health Questionnaire

Student Name:_____ **Date of Birth:**_____ **Entering Grade:**_____

Entering School:_____ **Previous School attended:** _____

Name and Number of Health Care Provider: _____

MEDICAL CONCERNS (Please circle yes or no)			**Medications/Additional Comments**
ADHD	Yes	No	
Allergies to food, insects, latex, other	Yes	No	(If yes, Please indicate specific allergy)
Asthma or other breathing related problems	Yes	No	
Bleeding Disorder	Yes	No	
Diabetes	Yes	No	
Gastrointestinal Issues	Yes	No	
Headaches/Diagnosed Migraines	Yes	No	
Cardiac/Heart Related Concerns	Yes	No	
Seizure Disorder	Yes	No	
Orthopedic concerns/assistive Devices	Yes	No	
Mental Health Issues	Yes	No	
Any other Health Concerns? Eating/sleeping, skin/teeth, weight, daytime wetting/stooling concerns	Yes	No	

My child takes the following medication at home: _____

My child will take the following medications daily at school: _____

My child will have the following medication as needed at school including Emergency Medication such as Epi-pen, Benadryl, Inhaler, Nebulizer Medication or seizure medication:

_____

*If YES, a CCPS Medication Order Form must be completed for <u>each prescription and over the counter medication to be given at school</u>. CCPS Medication Order Forms must be completed by your health care provider **each** school year. Adults must deliver and pick up all medications. PARENT INITIALS: _____*

Please provide a name and phone number where the nurse can contact you for further questions. Thank you!

Name: _____ *Phone Number:* _____