



Health Questionnaire

School Year: _____

A health concern was indicated on your child’s Confidential Student Health Information form. To ensure the best care for your child please complete this form, place it in an envelope and return it to the health office.

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

School Attending: _____ **Grade:** _____

Parent(s)/Legal Guardian(s): _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Physician/Clinic: _____ **Phone:** _____

Medical Condition(s)/Concern(s): _____

What treatment and/or medication is your child currently taking? _____

What situations could possibly occur because of this condition/concern? _____

Is your child receiving care from a healthcare professional for this condition? _____

If so, For how long: _____ how often? _____

Where can we reach you in the event of an emergency? _____

Which hospital is your preference if emergency transport is needed? _____

Describe any other important information that you think would be helpful in health planning for your child:

Signature of parent/legal guardian: _____ **Date:** _____

Please notify the appropriate school health office of any changes in your child’s health: _____