Health Questionnaire

Student's Full Name:_____

Date of Birth:_____ School:_____ Grade:_____

Any changes in the students health or medical information since last school year? yes no

Does your child have any of the following health conditions?

ASTHMA	Yes	No	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications:			

If yes, please download and submit the completed Asthma Packet found on the Health Services Tab of the DSC website

FOOD ALLERGIES/DIETARY NEEDS	Yes	No	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications:			

If yes, please download and submit the completed Food Allergy Packet found on the Health Services Tab of the DSC website

INSECT ALLERGIES	Yes	No	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications:			

If yes, please download and submit the completed Insect Allergy Packet found on the Health Services Tab of the DSC website

DIABETES	Yes	No	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications:			

If yes, please download and submit the completed Diabetes Packet found on the Health Services Tab of the DSC website

SEIZURE/EPILEPSY	Yes	No	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications/Device:			

If yes, please download and submit the completed Seizure/Epilepsy Packet found on the Health Services Tab of the DSC website

Student Full Name:_____

ENVIRONMENTAL ALLERGIES	Yes	No	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications:			

MEDICATION ALLERGY	Yes	No	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications:			

CARDIAC PROBLEM	Yes	No	Symptoms, treatments, restrictions, surgery and/or additional information:
Diagnosis Date:			
Medication/Device:			

GASTROINTESTINAL PROBLEM	Yes	No	Symptoms, treatments, restrictions, surgery and/or additional information:
Diagnosis Date:			
Medications/Device:			

KIDNEY/URINARY PROBLEM	Yes	No	Symptoms, treatments, restrictions, surgery and/or additional information:
Diagnosis Date:			
Medications/Device:			

EYE/VISION PROBLEM	Yes	No	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications/Device:			

EAR/HEARING PROBLEM	Yes	N	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications/Device:			

CHRONIC HEADACHES	Yes	No	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications:			

Student Full Name:_____

BLOOD/BLEEDING DISORDER	Yes	No	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications:			

PHYSICAL HANDICAP	Yes	No	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications/Device:			

SPEECH/LANGUAGE DIFFICULTY	Yes	No	Symptoms, treatments, restrictions, surgery and/or additional information:
Diagnosis Date:			
Medication/Device:			

ADD/ADHD	Yes	No	Symptoms, treatments, restrictions, and additional information:
Diagnosis Date:			
Medications:			

OTHER	Yes	No	Symptoms, treatments, restrictions, surgery and/or additional information:
Diagnosis Date:			
MedicationsDevice			

Please list any additional medications (not listed above) that the student takes:

Medication	**Dose**	**Time**	**Reason**	**To Be Given at School**
				Yes / No
				Yes / No
				Yes / No
				Yes / No

I understand that I may be required to furnish a doctor's statement verifying the above information. In accordance with board policy and procedures and state and federal law, medical information supplied to the Duneland School Corporation Health Services Department is confidential and will not be released to others not directly involved with caring for the student without written consent.

Parent/Guardian Name:_____ Date:_____

Parent/Guardian Signature:_____