

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.

*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 experiences, do they have, or are the presently:	No	Yes	Comments
1.Any serious injury or surgery			
2.Being treated for asthma, seizures, heart murmur, etc.			
3.Restrictions in physical education			
4.Allergies to medication, foods, insect bites, 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?			

I give my permission for my child to be treated with or be given the following as needed:

Tylenol	Ibuprofen
Cough Drops	Tums
Cough Syrup	Triple Antibiotic Cream - to be used on cuts
Benadryl - for signs of allergic reaction	Bismuth Tablets (Pepto-Bismol)
Saline eye drops	Anti-Itch Cream
Oragel/Anbesol	Dayquil
Other	Would you like to be notified when your child is treated with medications? Please circle your preference. <div style="display: flex; justify-content: space-around;"> Phone Note </div>

Parent's Name _____ 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.