



Student Enrollment Health Questionnaire

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

Entering School: _____ Previous School attended: _____

Health Care Provider Name: _____

Health Care Provider Phone Number: _____

MEDICAL CONCERNS (Please circle yes or no)

Medications/Additional Comments

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

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, Glucagon, Benadryl, inhaler, nebulizer medication or seizure medication:

*If YES, a CCPS Medication Order Form must be completed for each prescription and over-the-counter medication to be given at school. 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: _____ Today's date _____*

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

Name: _____ Phone Number: _____