# Central Dauphin School District
Student Health Services

## Annual Health Survey

- **Please sign and return this form to your school nurse as soon as possible**
- **Certain information may be shared with other school staff members when the Certified School Nurse deems it necessary for the health and safety of the student**

Student's Legal Name _____ Grade _____ Teacher _____

Parent Name (completing this form) _____

Physician's name _____ Phone _____

Does your child have any of these ongoing health conditions:

☐ Asthma ☐ Seizure Disorder ☐ Diabetes ( ☐ *Type 1* ☐ *Type 2)*

☐ Life Threatening Allergy (**Must** be documented with a physician's treatment order)

☐ Other _____

During this past year, has your child had:

Serious illness, injury, or operation? ☐ Yes ☐ No

If yes, please describe _____

Is your child under treatment? ☐ Yes ☐ No

If yes, physician's name _____

Have there been any family changes that affect your child in the past year (marriage, death, serious illness)?

_____

***Immunization updates*** *– please attach immunization record only if any immunizations have been given in the past year.*

**Medication administration at school requires a written doctor's order**.

Is your child presently taking any medication? ☐ Yes ☐ No

| Name of med: | Dose: | Reason: | When started: |
|---|---|---|---|
| | | | |
| | | | |

The following Over the Counter (OTC) medications (Tylenol, Advil and Tums) can be provided at school with a parent- or guardian-signed school permission form for Over-the-Counter Medication. This information is required to be updated annually.

Please mark those items or their generic substitutes which may be provided by the school nurse in the care of your child and sign the bottom of this form to acknowledge that you have reviewed the school over-the-counter medication policy.

☐ Acetaminophen (Tylenol) ☐ Tums ☐ Ibuprofen (Advil/Motrin)

Parent Signature: _____ Date: _____

*Rev. 3/5/2026*