

OSSD Annual Health Questionnaire - 2026-2027

Student's Name _____ **Grade** _____ **Teacher/TA/Program** _____
Date of Birth ____/____/____ **Age** _____

Name of child's primary provider: _____ **Has your child had a comprehensive annual well-child visit within the past year?** ☐ **Yes** ☐ **No** **Date of visit:** _____

Name of child's dentist: _____
Has your child had a dental exam/check-up in the last year? ☐ **Yes** ☐ **No** **Date of visit:** _____

Name of child's eye doctor: _____
☐ **Yes** ☐ **No** **Does your child wear glasses or contacts? Full time or part time use of glasses:** _____
☐ **Yes** ☐ **No** **If yes, has your child had an eye exam within the past year?** _____

☐ **Yes** ☐ **No** **Does your child have health insurance coverage?**
☐ **Yes** ☐ **No** **If no, would you like information about health insurance options?** _____

☐ **Yes** ☐ **No** **Does your child take any medication? (Continue on another sheet of paper if needed)** **Name of medication** _____ **Reason for medication** _____
_____ **Prescribing provider** _____ **Will medicine be used at school?** ☐ **Yes** ☐ **No**

NOTE: All medication must be in original containers. Parents/Guardians must bring medication to the school nurse and complete required paperwork. Prescription medications also require a written order from the prescriber.

☐ **Yes** ☐ **No** ☐ **Don't know/Not sure** **Has a health professional EVER said your child has asthma?**
☐ **Yes** ☐ **No** ☐ **Don't know/Not sure** **If Yes, does your child STILL have asthma?** _____

If Yes, please ask your provider for an Asthma Action Plan form and send a copy to the school nurse.

☐ **Yes** ☐ **No** **Does your child have allergies? If YES, please check and describe below. Include treatment needed.**
☐ **LIFE-THREATENING ALLERGIES** _____
☐ **allergies/sensitivities** _____

☐ **Yes** ☐ **No** **Has your child had any serious illnesses or injuries?**
If yes, please describe _____
Date of illness/injury _____

☐ **Yes** ☐ **No** **Does your child have any physical disabilities, including speech or hearing?**
If yes, please explain: _____
Are there any limitations on activities? _____

Please turn over the form and continue on the back.

__Yes __No Does your child have any other health conditions the school nurse should know about? If yes, please describe: _____ Are there any limitations on activities? _____

__Yes __No Has your child experienced any social or emotional problems that may affect his/her adjustment to school? If Yes, please explain: _____

May the school nurse give your child the following medications (in age and weight appropriate doses)?

__Yes __No Tylenol (acetaminophen) **__Yes __No Advil/Motrin** (ibuprofen) **__Yes __No Tums** (antacid)

In accordance with the new legislation S.187 each public and approved independent school in the State shall permit students, with the written authorization of a parent or guardian, to possess and self-administer a topical, nonaerosolized sunscreen while on school property or at a school-sponsored event or activity without being required to provide a medical provider's note or prescription or having to store the sunscreen in a specific location. A school shall keep on file a parent's or guardian's written authorization. School personnel shall not be required to assist students in applying sunscreen and shall not be responsible for ensuring that the sunscreen is applied to the student.

I consent to my child using nonaerosolized sunscreen at school. **__ Yes __ No**

Student's Name _____ Date of birth _____

I understand that in the event of an accident or sudden illness, the school will try to contact me. If the school is unable to reach me, I authorize school personnel to seek emergency medical care, including transportation to GMC or the nearest medical facility. I also understand that ambulance transportation will be at my expense.

I give my permission for (provider's name) _____ to exchange information with the school nurse regarding my child's diagnosis, treatments, medications, and immunizations. I understand that this information will be kept strictly confidential.

I give permission for the school to share with (provider's name) _____ my child's educational records as it relates to attendance or to conditions that are managed by my child's healthcare provider.

Parent/Guardian Signature _____ Date _____

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