SARGENT PUBLIC SCHOOL YEARLY UPDATE HEALTH QUESTIONAIRE

STUDENT NAME_____ GRADE_____

PLEASE CIRCLE THE ANSWER ON THE HEALTH QUESTIONS BELOW AND FILL IN NEEDED INFORMATION:

Approximate date of last exam Dr._____ Dentist_____ Optometrist_____

Is your child allergic to any medications? **No Yes** Names and reactions _____

Does your student have any food allergies/intolerances and what is their reaction? **No Yes** Please list

_____

Do they require a special diet? **No Yes** Type of diet_____

Other allergies or sensitivities (such as bee stings, strong fumes, seasonal allergies) **No Yes** Please list _____

_____

Does your student have asthma or any breathing difficulties? **No Yes** Do they take medications for this? **No Yes**

Please list medications_____

Does your student have ADHD, behavioral, emotional or psychiatric concerns? **No Yes** Please explain and list any medications_____

Has your student had any surgical procedures or operations in the last year? **No Yes**

_____

Is your student diabetic? **No Yes** How often do you check blood sugars and list medications needed_____

_____

Does your student **now** have a health condition under treatment? (Not previously listed) _____

_____

Does your student have glasses? **No Yes** Do they wear contacts? **No Yes**

Do they have a hearing problem or use a hearing assistive device? **No Yes** _____

Does your student require routine prescription or over the counter medication? **No Yes** Please list (If medication needs to be given at school a medication form is required) _____

_____

Additional Health Information that the school nurse should know

_____

_____

PARENT OR GUARDIAN SIGNATURE_____ **DATE**_____