ANNUAL STUDENT HEALTH INFORMATION SURVEY

School Name: _____

Name:	ID:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)		Home Phone: Cell Phone:	Date:

Does your child have any of the following conditions?	YES	NO	If Yes, please explain and include date:
Allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Bee Sting Allergy ☐ Breathing Difficulty ☐ Rash ☐ Swelling (sting site only) ☐ Itching ☐ Swelling (all over body) ☐ Swelling (face only)	☐	☐	☐ Anaphylaxis Action Plan provided to health office ☐ Epinephrine Auto-Injector (EPI-PEN)Required May self-carry ☐No ☐Yes
Food Allergy Type: _____ ☐ Breathing Difficulty ☐ Rash ☐ Swelling (all over body) ☐ Itching ☐ Swelling (face only)	☐	☐	☐ Epinephrine Auto-Injector (EPI-PEN)Required May self-carry ☐No ☐Yes ☐ Food Allergy Action Plan provided to health office ☐ Physician Statement for Food Substitution provided to health office
Asthma Does student carry inhaler with him/her: ☐No ☐Yes	☐	☐	☐ Inhaler provided to health office ☐ Asthma Care Plan provided to health office
Diabetes	☐	☐	☐ Diabetic Care Plan provided to health office
Convulsion/Seizure Disorder Date of Last Seizure: _____	☐	☐	☐ Seizure Care Plan provided to health office
Vision problem or condition	☐	☐	☐ Glasses ☐ Contacts
Hearing problem or condition	☐	☐	☐ Hearing aid ☐ Cochlear implant

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Diabetes
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition: _____
☐ Urinary Condition
☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐Crutches ☐Walker ☐Wheelchair ☐AFOs ☐Other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is your child currently under medical treatment/care for a long-term or chronic condition? ☐No ☐Yes
If YES, please explain: _____

Does your child have any special needs or necessary precautions while in school? ☐No ☐Yes
If yes, please explain: _____

HEALTH INFORMATION MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL

_____ _____ _____
Parent/guardian signature Relationship to student Date