

SCHOOL HEALTH QUESTIONNAIRE
Individual Health Information for the School Nurse

Student's Name: _____ Grade: _____

1. Has your child had chicken pox? Yes____ No____ Date _____
or Chicken Pox Vaccine Date _____

2. Has your child had any hospitalization, accidents or serious illnesses within the past year?
Yes____ No____ If yes, please elaborate _____

3. Is there any chronic condition or disease that I should be aware of that may limit your child's activities? Yes____ No____ If yes, please elaborate _____

4. Does your child have any known allergies? Yes____ No____ If yes, please elaborate:

5. Does your child have any other medical or health problems I should be aware of?

Yes____ No____ If yes, please specify _____

6. Will your child be on any medication that must be administered during school hours?

Yes____ No____ If yes, NAME OF MEDICATION _____

Please note that school policy for medication requires written permission from a physician as well as written permission from a parent/guardian. The medication must be brought to school (by an adult) in the original container appropriately labeled by the pharmacy or physician.

Parent/Guardian Signature _____

Phone _____