Allen County Non-Public School Association

HEALTH QUESTIONNAIRE

(Parent/Guardian needs to complete)

Please Print

Student_____Grade_____Date of Birth___/___/___

Address_____

Phone Number_____

Father's name_____Mother's name_____

Student lives with_____

Health History

Check all that apply to your child

ADD/ADHD (circle)
Allergy (specify)
Seasonal _____
Food _____
Other _____
Asthma
Chickenpox
Diabetes
Chronic Ear Infections

Emotional Disorder
GI/GU Issues
Hearing Impairment
Hepatitis
Measles/Mumps/Rubella
Mononucleosis
Physical Handicaps
Pneumonia
Rheumatic Fever

Scarlet Fever
Seizures
Tuberculosis
Vision Impairment
Whooping Cough
____Other_____
____Other_____
____Other_____
____Other_____

Any checks made above, please give explanations and dates of diagnosis:

_____

_____

Has your child had an infectious/communicable disease other than those listed above? Please explain, giving relevant dates:

_____

_____

Does your child require the use of an EPI-PEN for allergic reactions?_____

CONTINUED ON REVERSE

Please be specific and include the month/year:

Severe Illnesses: _____

Severe Injuries: (head injury, fractures, etc.): _____

Diagnostic Procedures: _____

Hospitalizations: _____

Surgical Procedures: _____

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment?

_____

_____

_____

Please list any condition that should be considered in planning your child's school day:

_____

_____

_____

Physician's Name: _____ Phone # _____

Dentist's Name: _____ Phone # _____

Eye Doctor's Name _____ Phone # _____

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

_____ _____

Parent/Guardian signature Date

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY

CUSTODIAL PARENT OR LEGAL GUARDIAN: Please complete this form and return it to the office AS SOON AS POSSIBLE. This form will be kept on file in the office. Information may be shared with other staff when necessary to maintain the safety of the student.

STUDENT NAME_____ SS#_____

Street Address_____ Date of Birth_____

City_____ Zip Code_____ Phone #_____

Name of Legal Guardian(s)_____ Relationship_____

Father's Name_____ Phone #_____

Place of Employment_____ Phone#_____

Mother's Name_____ Phone#_____

Place of Employment_____ Phone #_____

DOES YOUR CHILD HAVE:

ALLERGIES? (if yes, explain)

_____

_____

Does your child require the use of an Epi-Pen for allergic reactions?_____
******If yes, you must provide an Epi-Pen to the school office to be available if needed.**

ASTHMA? ( ) allergy induced ( ) anxiety induced ( ) exercise induced ( ) other

What controls the attack best?_____

_____

DIABETES? Has had since age_____ Controlled by ( ) diet only ( ) insulin ( ) insulin pump

Additional diabetic information (continue on reverse if necessary)_____

_____

EPILEPSY? (list type)_____**Controlled by ( ) medication ( ) other**

How often does student have seizures?_____

List known triggers_____

Please list any other medical problems or health concerns with any special instructions.

_____

_____

Please list any medications taken on a regular basis and the condition being treated.

_____

_____

IN CASE OF ILLNESS OR EMERGENCY AT SCHOOL

I understand that every effort will be made to contact the custodial parent or legal guardian. When this fails, the people you have listed on the Emergency Information sheet will be contacted and those persons will speak on behalf of the student with the same authority as the parent. When no designated contact can be reached, or a serious medical emergency exists requiring medical treatment beyond what can be provide at the school to maintain safety and/or life, the student will be transported by EMS to the emergency room.

I also understand that it is my responsibility to keep the school office informed of any medical condition or illness that the student may have. It is also my responsibility to provide to the school any medication that is needed by the student and the proper Student Medication Information and Consent Form must be on file for each medication to be administered. Phoned or faxed permissions will not be accepted. Medication must be in the original container and must include the student's name and dosage and must not be expired.

_____ _____

Parent's Signature Date