STUDENT HEALTH SURVEY (2019-20 School Year)

STUDENT'S NAME: **GRADE:**

CONCERNS	YES	NO	MORE INFORMATION	MEDICATIONS
Known Allergy to Bee Stings			Reaction:	Epi-Pen?
Food Allergies: specify food			Reaction:	Epi-Pen?
Asthma			**Need emergency care plan and medicaiton form for inhaler use**	Inhaler in office? Will carry?
Attention Deficit				Will student take meds at school?
Bowel or Bladder Issues				
Diabetes			Must provide "Diabetes Management Plan" from Dr each school year	Insulin injection? Pump?
Epilepsy/Seizure Disorder				
Hearing Issues			Hearing Aid? Yes No	
Heart Condition				
Migraines				Will student take meds at school?
Orthopedic Condition				
Physical Restrictions				
Visual Condition			Contacts Glasses	

Other Health Issues:

ALL MEDICATIONS TAKEN BY STUDENT AT HOME/SCHOOL: (Please list drug names and dosage)

SPECIAL NEEDS AT SCHOOL:

It is the parent's responsibility to contact the school with any health changes during the school year. Relevant health information will be shared with necessary staff members for the safety of your child during the school day.

Parent signature _____ Date _____