 **Health Questionnaire**

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_**

Please ✔ “Yes” or “No” after each question. If “Yes,” provide dates and explain; use back of page if needed.

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| * **Allergic to any medications?** |  |  |
| * **Allergic to any foods?** |  |  |
| * **List any other allergies:** |  |  |
| * **Food/dietary restrictions?** |  |  |
| * **Asthma? Will your child need an inhaler at school?** |  |  |
| * **Diabetes?** |  |  |
| * **Seizure disorder?** |  |  |
| * **Heart or cardiovascular condition?** |  |  |
| * **Medication at home?** |  |  |
| * **Medication during the school day?** |  |  |
| * **ADD/ADHD?** |  |  |
| * **Any physical restrictions?** |  |  |
| * **Psychological/emotional issues?** |  |  |
| * **History of hospitalization or surgery?** |  |  |
| * **Concussion or severe head injury? If yes, provide date:** |  |  |
| * **Vision problems? Glasses/contacts?** |  |  |
| * **Hearing problems? Hearing aid?** |  |  |
| * **Chicken pox disease? If yes, provide date:** |  |  |
| * **Urinary or bowel problems?** |  |  |
| * **Any physical, developmental, or other health problems at birth?** |  |  |
| * **Any other health problems/issues?** |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian signature Date**