 **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**