HEALTH SCREENING SURVEY – CONFIDENTIAL
(please fill in all blanks and sign)

Chronic Health Conditions:

Asthma _____
Seizure Disorder _____
Diabetes _____
Skin Conditions _____

Attention Problems:
ADD _____
ADHD _____

Vision Problems:

Wears Glasses _____
All the time? _____
Contact Lenses _____
Other Concerns _____
_____

Hearing Problems:

Frequent ear infections _____
Tubes _____
Known hearing loss _____
Other Concerns _____
_____

Does your child have any allergies to any of the following:

Medications: Y N _____
What type of medication

Food: Y N _____
Please specify what types of food

_____
Please specify what type of reaction to the food

Other: _____

Does your child take medication on a daily basis: Y N

Name & dosage of medication: _____

Will your child be taking medication at school: Daily _____ or As Needed _____

Other health concerns: _____

_____

Please notify the school office if there are any changes in your child's health during the school year. Keeping our records as current as possible is important to our staff and your child's well being.

Y N I/We give permission for the school to request aid of the closest Rescue Unit in the event of a serious accident, injury, or illness.

_____ _____
Parent/Guardian Signature Date