

ANNUAL HEALTH SURVEY

Student's Name _____ Grade _____

YES NO

1. Does your child take any medications regularly? If yes, please list medication(s) and why prescribed. _____

2. Does your child have asthma or other respiratory problems? _____

3. Has your child ever used albuterol (Ventolin/Proventil)- by nebulizer or inhaler in the past? _____
4. Is your child allergic to any food or insect bites? _____

5. Has your child ever developed hives when they have eaten a food or been stung by an insect? _____
6. Does your child have any other type of allergies? _____

7. Does your child have any heart problems and if so, are there activity restrictions? _____

8. Does your child have any bladder or bowel problems? _____

9. Does your child have any hearing or visual problems? _____

10. Has your child ever had a seizure? _____

11. Has your child had any immunizations during the past year? If yes, list vaccine and date

12. Has your child ever had the chicken pox? _____
13. Has your child received the chicken pox vaccine? Date: _____
14. Has your child been examined by a dentist in the past year?
15. Has your child been examined by an eye doctor in the past year?

Please write on the back of this form any other information you feel we may need concerning your child's health.

I grant my permission for the school to release any information regarding my child's health to the appropriate staff members that the school determines should have access to this information.

PARENT/GUARDIAN SIGNATURE

DATE