MSAD #75

Health Questionnaire

(To be filled out by parent/guardian)

Student's Name ______________________________ Grade _______ Date of Birth ______________
Mother/Guardian ______________________________ Phone(s) ______________________________
Father/Guardian ______________________________ Phone(s) ______________________________
Primary Physician ______________________________ Date of Last Physical Exam ______________
Dentist ______________________________ Date of Last Dental Exam ______________

PLEASE CHECK ALL THAT APPLIES TO YOU CHILD

☐ ADD/ADHD ☐ Heart Condition ☐ Frequent Headaches/Migraines
☐ Frequent Stomachaches ☐ Mental Health Issues (depression, anxiety, etc.)
☐ Recent serious illness ☐ Serious injuries ☐ Hospitalizations/Surgery
☐ Seizure Disorder/Epilepsy ☐ Diabetes ☐ Scoliosis
☐ Asthma
☐ Please explain any situations or conditions checked off above including any other chronic health concerns not listed ______________________________
____
____

☐ Allergies (food, medication, environmental or insect stings)

Explain/List: ______________________________
Has your child been prescribed an Epi-pen? ☐ Yes ☐ No Is Benadryl used? ☐ Yes ☐ No

List all medications, with dose and frequency, taken by your child:

At Home ______________________________
At School ______________________________

Does your child have health insurance? ☐yes ☐no
Does student wear glasses ☐yes ☐no, contact lenses? ☐yes ☐no Date of last exam________
Does student have history of hearing problems? ☐yes ☐no Wear hearing aids? ☐yes ☐no
Does your child have any physical restrictions? ______________________________

Comments______________________________

Are there any family situations that may affect your child that we should be aware of? (illness, divorce, deployment) ______________________________
____

______________________________ ____________________
Signature of Parent/Guardian Date

*See student handbook for the district medication policy & standing orders from the district peditrician.