PISD HEALTH SURVEY

Last Name:_____ **First Name**:_____ **MI:**_____ **Grade:**_____

School:_____ **Birthday**:_____ **SEX:** M / F

ALLERGIES: YES_____ NO_____

___Medication (specify)_____

___Food or nuts (specify)_____

___Insect bites (specify)_____

___Other substances (specify)_____

Does your child need emergency medication for an allergic attack? YES_____ NO_____

Does your child need an epinephrine pen? YES_____ NO_____

Explanation: _____

HEALTH CONDITIONS THAT YOUR CHILD MIGHT HAVE:

___Asthma	___Glasses/Contacts	___Mental retardation	___Head injury
___Diabetes	___ADD/ADHD	___Autism	___Frequent headache/migraines
___Shunts (specific)	___Neuro-muscular disease	___Heart problem/defect	___Recurrent ear infections
___Panic attacks	___Stomach problems	___Hearing problems	___Bowel problems
___Eating disorder	___Kidney problems	___Speech impairment	___Bone disease
___Head injury	___Vision problems	___Special Dietary Plan	___Development delays
___Oral/dental problems		___Epilepsy/seizure disorders	

Previous surgeries:_____

Previous trauma:_____

Is this condition or conditions under control at this time? : YES___ NO___ If NO when was the last time your child experienced any problems w/this condition that required medical treatment? _____

Explanation:_____

MEDICATIONS

Will your child need to take medications at school? YES___ NO____ Please list medications:_____

All medications must be furnished by parent. Prescriptions meds must be in the original container with the appropriate label affixed. The medications must be accompanied with a medication permission sheet signed by the parent. Over the counter medications must be in an original container, with the student's name written on it and accompanied by written permission from the parent or guardian.

Medications that your child takes regularly at home and not at school:

What?	Strength?	How Many?	Time of day?	Only as needed?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Does your child have mobility problems? ____Wheelchair ____Walker ____Braces ____Crutches ____Other

Does your child require? ____Tube feeding ____Catheter care ____Diabetic care ____Other

Please add any information or instructions that you have in order that we will be able to take care for your child:_____

_____

Parental Consent: I consent to and authorize the school to disclose the above information to those within the school who have a need to know for legitimate educational purposes. If between this date, and while the student is enrolled in school, if any illness or injury occurs that may limit this student's participation, I agree to notify school authorities of such illness or injury.

Date: _____ Parent or Guardian Signature:_____