STUDENT HEALTH QUESTIONNAIRE

LAST NAME	FIRST NAME	GENDER	DATE OF BIRTH

HEALTH HISTORY

Is your child having any of the following problems?

	Yes	No		Yes	No
Allergies – Medication	❒	❒	Allergies - Food	❒	❒
Allergies – Bee Sting	❒	❒	Allergies – Other (identify below)	❒	❒
Hay fever	❒	❒	Asthma	❒	❒
Wheezing, shortness of breath	❒	❒	Heart disease/defect	❒	❒
Epilepsy/Seizures	❒	❒	Migraines/headaches	❒	❒
Diabetes	❒	❒	Hypoglycemia	❒	❒
Vision problems	❒	❒	Hearing problems	❒	❒
Speech problems	❒	❒	Eczema or frequent skin rashes	❒	❒
Other Health Issue(s)/Physical Limitations/Restrictions (please explain)				❒	❒

If you answered Yes to any of the above, please indicate below the severity & specific nature:

_____

_____

Is your child regularly taking any medications? ❒ Yes (explain below) ❒ No

If yes, what medication? _____

Reason for medication? _____

Sign Here

Parent Signature **Date**

RESTRICTIONS

If restrictions are requested/recommended, signature of the examining health official is required.

Is there any defect of vision, hearing, or other condition that medically requires specific seating or other action?

❒ No ❒ Yes If yes, please explain._____

_____

_____

Should the student's activity be restricted because of any physical defect or illness? ❒ No ❒ Yes

If yes, please circle appropriate area and explain degree of restriction.

Classroom Playground Gymnasium Swimming Pool Competitive Sports Other

_____

_____

_____

Examiner's Signature **Date** **Examiner's Name (print/type)** **Degree/License**

Revised 06/16