Constantine Public Schools

STUDENT HEALTH QUESTIONNAIRE

Last Name	First Name	Date of Birth	__ Male __ Female

HEALTH HISTORY

Is your child having or had any of the following problems?	Yes	No
Allergies or reactions to food, medication, bee stings, etc.	___	___
Hay Fever, Asthma, Wheezing, shortness of breath	___	___
Eczema or frequent skin rashes	___	___
Convulsions/Seizures	___	___
Heart Trouble	___	___
Diabetes	___	___
Hearing problems	___	___
Vision problems	___	___
Other Health Issue/Physical Limitations/Restrictions (please explain)	___	___

Please explain problems identified above. If your child has health issues (example-allergy), what type of reaction will he/she experience and what type of treatment is necessary? Doctor records required.

_____

_____

Has your child had chicken pox disease? __Yes __No

If Yes: Date of Disease_____

If No: Date of Immunizations (2 doses)_____

Is your child regularly taking any medication? __Yes __No

If yes, what medication? _____

Reason for medication? _____

Where is medication administered: __Home __School __Both

If medication is administered at school, an "AUTHORIZATION TO ADMINISTER MEDICATION" Form **must** be completed by parent. *Medication will not be dispensed without completed form. All Medication must be in the original container*

Does this child have any problems that might influence his school adjustment: __Yes __No

If yes, please state: _____

_____

If you or your spouse cannot be reached in the case of an emergency, would you want the Teacher, Principal or Office staff to seek medical aid for your child on your behalf? __Yes __No

Parent Signature: _____ Date: _____