

Has your child been diagnosed as having:

Allergies: Yes ___ No ___ To what? _____ Medication _____
Asthma: Yes ___ No ___ Triggers _____ Medication _____
Diabetes: Yes ___ No ___ Treatment (insulin type and frequency) _____
Epilepsy or seizure disorder: Yes ___ No ___ Orthopedic Difficulties: Yes ___ No ___
Heart condition: Yes ___ No ___ Congenital Defects: Yes ___ No ___
Attention Deficit Disorder: Yes ___ No ___ Medication: _____

Has your child had:

Eczema: Yes ___ No ___ Hives: Yes ___ No ___
Fractures: Yes ___ No ___ Operations: Yes ___ No ___
Serious injury: Yes ___ No ___ Serious Illness: Yes ___ No ___

Frequent:

Headaches: Yes ___ No ___ Nose Bleeds: Yes ___ No ___
Ear infections: Yes ___ No ___ Sore Throats: Yes ___ No ___
Abdominal pain: Yes ___ No ___ Painful urination: Yes ___ No ___

Does your child have any difficulty with:

Doing close work: Yes ___ No ___ Wear glasses: Yes ___ No ___
Seeing distant objects: Yes ___ No ___ Wear contacts: Yes ___ No ___
Hearing: Yes ___ No ___ Wear a hearing aid: Yes ___ No ___
Speech: Yes ___ No ___ Receive Speech Therapy: Yes ___ No ___

Does your child take any daily medication? : Yes ___ No ___

Name/ dose/ frequency of medication: _____

Does your child take any EMERGENCY MEDICATION: Yes ___ No ___

Name/dose/when needed: _____

Does this medication need to be kept in school: Yes ___ No ___

Does your child have any problems that would prevent participation in regular physical education classes or playground activities? Yes ___ No ___

Are there any other health concerns you wish to discuss with the nurse?

Please note if there is anything you wish to discuss with the school staff (principal, administrator, nurse, teacher).