<u>**Health Questionnaire**</u>

Please complete this form for each student and return it to the school office August 27, 2018.

Student's Name ____

Date of Birth _______________________

1. Does your child have any condition(s) that school staff should be aware of?
   YES ___ NO ____ If yes, please check and comment below.

( ) Arthritis	( ) Diabetes	( ) Heart Problems
( ) Asthma	( ) Ear Problems	( ) Physical Handicap
( ) Bladder/Kidney	( ) Epilepsy/Seizure	( ) Other
( ) Bone/Muscle	( ) Eye Problems	

   Note: Medical conditions may require a change of clothing during the school day. If necessary, please make arrangements with the classroom teacher to store an extra set of clothing at school.

2. Does your child have any allergies to foods, medications, bee stings, etc.?
   YES ___ NO ____ If yes, please check and comment below.

3. Are any of the above conditions or allergies life-threatening?
   YES ___ NO ____ If yes, please check and comment below.

4. Is your child on any regular medications?
   YES ___ NO ____ If yes, please check and comment and list medications, including inhalers. If your child needs to receive medication from the school staff during school hours, please call the school office for a medication consent form or download one from the school website.

5. Is your child's activity restricted in any way?
   YES ___ NO ____ If yes, please check and comment below.

Comments:
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The above information will be shared with the appropriate school staff to meet the educational and safety needs of your child. Information will be kept confidential.

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Parent/Guardian Signature Date