Student Name: DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_

Doctor: Phone: \_\_\_\_\_\_\_\_\_ Hospital Preference:

**DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?**

1. Allergy (describe allergen, reaction and typical treatment) Yes No
2. Asthma Yes No
3. Diabetes Yes No
4. Epilepsy/Seizures Yes No
5. Physical limitations Yes No
6. Vision or Hearing loss Yes No
7. Heart or Lung Condition Yes No
8. Bowel, Bladder, or Kidney Condition Yes No
9. Muscle, Bone, or Joint Condition Yes No
10. Skin Condition (other than acne) Yes No
11. Other Medical Condition Yes No

**WITHIN THE PAST YEAR, HAS YOUR CHILD:**

1. Developed any new conditions / concerns? Yes No
2. Had a significant injury (fracture, dislocation, etc)? Yes No
3. Had any head injuries (concussion, skull fracture)? Yes No
4. Had any episodes of fainting or dizziness? Yes No
5. Had any surgery or hospitalization? Yes No

**YOUR CHILD:**

1. Is currently seeing a doctor for a concern? Yes No
2. Is currently taking medication at home? Yes No
3. Is required to take medication during the school day? Yes No

**ANY CONCERNS YOU WANT TO DISCUSS WITH THE NURSE?** Yes No

**If you checked yes to any of the above questions, please explain below.** *Continue on back if needed.*

Parent / Guardian (printed): Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Parent / Guardian (signed):