

SCHOOL HEALTH QUESTIONNAIRE  
Individual Health Information for the School Nurse

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

1. Has your child had chicken pox? Yes\_\_\_\_ No\_\_\_\_ Date \_\_\_\_\_  
or Chicken Pox Vaccine Date \_\_\_\_\_

2. Has your child had any hospitalization, accidents or serious illnesses within the past year?  
Yes\_\_\_\_ No\_\_\_\_ If yes, please elaborate \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Is there any chronic condition or disease that I should be aware of that may limit your child's activities? Yes\_\_\_\_ No\_\_\_\_ If yes, please elaborate \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Does your child have any known allergies? Yes\_\_\_\_ No\_\_\_\_ If yes, please elaborate:

\_\_\_\_\_

\_\_\_\_\_

5. Does your child have any other medical or health problems I should be aware of?

Yes\_\_\_\_ No\_\_\_\_ If yes, please specify \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Will your child be on any medication that must be administered during school hours?

Yes\_\_\_\_ No\_\_\_\_ If yes, NAME OF MEDICATION \_\_\_\_\_

Please note that school policy for medication requires written permission from a physician as well as written permission from a parent/guardian. The medication must be brought to school (by an adult) in the original container appropriately labeled by the pharmacy or physician.

Parent/Guardian Signature \_\_\_\_\_

Phone \_\_\_\_\_