



Lutheran South Unity School
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Allen County Non-Public School Association

HEALTH QUESTIONNAIRE

(Parent/Guardian needs to complete)

Please Print

Student _____ Grade _____ Date of Birth ___/___/___

Address _____

Phone Number _____

Father's name _____ Mother's name _____

Student lives with _____

Health History

Circle all that apply to your child

- | | | |
|---|--|--|
| <input type="checkbox"/> ADD/ADHD (circle) | <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Allergy (specify)
Seasonal _____
Food _____
Other _____ | <input type="checkbox"/> GI/GU Issues | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Vision Impairment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles/Mumps/Rubella | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Physical Handicaps | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |

Any circles made above, please give explanations and dates of diagnosis.

Has your child had an infectious/communicable disease other than those listed above? Please explain, giving relevant dates:

Does your child require the use of an EPI-PEN for allergic reactions? _____

CONTINUED ON REVERSE

Please be specific and include the month/year:

Severe Illnesses: _____

Severe Injuries: (head injury, fractures, etc.): _____

Diagnostic Procedures: _____

Hospitalizations: _____

Surgical Procedures: _____

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment?

Please list any condition that should be considered in planning your child's school day:

Physician's Name: _____ Phone # _____

Dentist's Name: _____ Phone # _____

Eye Doctor's Name _____ Phone # _____

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

Parent/Guardian signature

Date