Brasher Falls Central School
Health Questionnaire

Student Name _____ **Grade**_____ **ID** _____

Has your child ever had?

	Yes	No	Date
1. Epilepsy, convulsions	____	____	_____
2. Heart or Blood pressure problems	____	____	_____
3. Bleeding Disorder	____	____	_____
3. Asthma	____	____	_____
4. Allergies-Environmental	____	____	_____
5. Diabetes	____	____	_____
6. Recent Surgery	____	____	_____
7. Concussion	____	____	_____
8. Loss of eye, Kidney or testicle	____	____	_____
9. Drug Allergies	____	____	_____

Please List with typical reaction and treatment given_____
_____

10. Food Allergies ____ ____ _____

Please List with typical reaction and treatment given_____
_____

11. Fractures _____ _____ _____
12. Recent Immunization update _____ _____ _____

Please attach Physician Documentation

Please explain any Yes answers:
_____
_____

Current Medications taken at home
_____

Medications needed during school hours
_____

Treatments needed During School hours
_____

Medical Assistive Devices used by your child ie IV ports, G-Tubes, hearing aides, Prosthesis _____

Parent Guardian Signature _____ **Date** _____