Benjamin SCHOOL DISTRICT 25

Health Record Questionnaire

In an effort to keep your child's health records complete and up-to-date, we ask your cooperation in providing the following information: ***(PLEASE COMPLETE AND RETURN WITH PACKET TO THE OFFICE)***

	YES	NO
1) Has your child ever had any serious illness or injury? If yes, please specify._____	_____	_____
2) Is your child allergic to insect stings or have any known allergies? If yes, please specify._____	_____	_____
3) Does your child have asthma? If yes, please note medication and restrictions, if any._____	_____	_____
4) Does your child have a history of seizures? If yes, please comment._____	_____	_____
5) Has your child ever been diagnosed with Diabetes?	_____	_____
6) Is your child taking any medication daily? If yes, please specify._____	_____	_____
7) Does your child need medication? If yes, a "School Medication Authorization" form must be completed, and signed by a doctor and parent each year before the school can dispense it. Forms are available in the school office and website.	_____	_____
8) Does your child have any known speech, vision or hearing difficulties? If yes, please specify._____	_____	_____
9) Is there anything about your child's health, physical or emotional background that you would like the teacher or nurse to know? If yes, please specify._____	_____	_____

Child's Name _____

Parent/Guardian's Name _____ **Date** _____

Telephone _____ **Current Grade**_____