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____________________

Revised February 1996