



[ONE FORM PER STUDENT]

School Nurse Questionnaire

2024-2025

Dear Parent,

In an effort to help us provide optimum health services for your child and keep your child's school health record complete and up-to-date, we ask your cooperation in providing the following information:

1. Has your child had any serious illness, operation or injury? If yes, please specify: _____ Yes No

2. Does your child have any known allergies? If yes, please note allergy and treatment: _____ Yes No

3. Does your child have asthma? If yes, please note medication and restrictions, if any: _____ Yes No

4. Is your child allergic to insect stings? If yes, specify treatment procedure: _____ Yes No

5. Is your child on any medications? If yes, specify: _____ Yes No

6. Does your child need medication in school? If yes, please complete the "School Medication Permission Form" and follow its directions. Yes No
7. Does your child have a special learning need or receive special services of any type? If yes, please explain: _____ Yes No

8. Does your child have any vision or hearing problems? If yes, please explain: _____ Yes No

9. Does your child have any health concerns of which the school should be made aware? If yes, please explain: _____ Yes No

Child's Name: _____ Grade: _____ Birth Date: _____

Parent Signature: _____ Date: _____