Confidential Health Questionnaire

Child's Name:	M / F Birthdate:
Physician:	Phone number:
Dentist:	Phone number:
☐ Check here if your child has NO KNOWN HEALTH CONCERNS	
☐ Check here if your child has KNOWN HEALTH CONCERNS and check all that apply below: o ADD/ADHD	
o Asthma	
o Severe Allergy to_____ ☐ Has an epinephrine auto-injector	
☐ Seizures	
☐ Diabetes ___Type I ___Type II	
☐ Other:	
☐ Check here if your child wears glasses or contact lenses.	
☐ Check here if your child has a hearing loss or uses hearing aids.	
☐ Check here if your child has had chicken pox.	
☐ My child has dietary restrictions (please explain)	
Does your child have a condition that limits participation in : ☐ Classroom ☐ Physical Education Explain:	
List all medication your child takes and indicate whether it is needed at home, school or both. *Note: If your child requires medication while attending school, there are forms that need to be completed by you and your child's physician so that the school may dispense the medication safely (California Education Code 49423).* AT HOME: AT SCHOOL:	
Special Instructions/Comments/Health Needs/Emergency Care Plans:	
If you would rather not use this form or would like to discuss any matter with the School Nurse, you may call your child's school and request that the School Nurse call you.	
Name of person completing form Relationship to the student Date	