ANNUAL HEALTH SURVEY

Student Name:
Grade:
School:

My child is taking the following prescribed medication at home:
Dosage

My child will need to have the following medication administered at school:
Dosage
As a reminder, a medication consent form must be completed and on file before the medication can be administered.

My child has the following allergies: Medication ☐ Seasonal ☐ Other, please explain

My child has been hospitalized during the past year for the following reason(s):

My child had the following communicable disease(s) in the past year:

My child had the following serious injury this past year:

My child has the following activity restriction(s):

My child has the following health issues: Asthma ☐ Seizures ☐ Diabetes ☐ Bee Sting Reaction ☐
Food Allergy ☐ Other, please explain

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My child has received the following immunization(s) **over the past year**:
Vaccine Dose # Date
Vaccine Dose # Date
Vaccine Dose # Date
Vaccine Dose # Date
Vaccine Dose # Date
OR my child had Chicken Pox on Date

It is the parent or guardian's responsibility to provide school with current immunization records.

None of the above statements pertain to my child ☐

The school health program is not legally responsible, not is it equipped or staffed to provide extended day care for ill students.

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The school nurse has my permission to share pertinent health information with appropriate school personnel.

Parent/Guardian Electronic Signature (initials): Date:
Your typed initials will serve as your signature