

# Annual Health Questionnaire

Griswold Public Schools

(Information provided will be shared with appropriate staff as stated in the Family Education Right and Privacy Act (FERPA))

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Please answer (Y) yes or (N) no, my child.....

1. Has been diagnosed with **ASTHMA** Y N
2. Has had **SEIZURE** activity in the past 12 months. Y N  
Specify: \_\_\_\_\_  
Medication: \_\_\_\_\_
3. Please list any **medication/s** your child will need to:  
**TAKE IN SCHOOL** \_\_\_\_\_
4. Was seriously **ill/sustained injury** or **had surgery** in previous 12 months. Y N  
Specify: \_\_\_\_\_
5. Is allergic to **Bees/Wasps** Y N  
Specify: \_\_\_\_\_  
Medication: \_\_\_\_\_
6. Is allergic to **Medication/Latex/Other** Y N  
Specify: \_\_\_\_\_
7. Allergic to foods Y N  
Food(s): \_\_\_\_\_  
Reaction(s): \_\_\_\_\_  
Medication: \_\_\_\_\_
8. Is **DIABETIC: TYPE I** \_\_\_\_\_ **TYPE II** \_\_\_\_\_ Y N
9. Wears glasses/Contacts Y N
10. Has a hearing aid and/or hearing problems Y N
11. Has specialized equipment:  
(i.e wheelchair, leg braces, assistive feeding devices, crutches, walker, catheterization, ostomy supplies, diabetic meters, etc.) Y N  
Specify: \_\_\_\_\_
12. Has a diagnosis of **ADD/ADHD** Y N
13. Has a diagnosis of **Depression** Y N
14. Has a diagnosis of **Anxiety** Y N
15. Has a diagnosis of **Manic Depression or Bipolar** Y N
16. Has **Headaches/Migraines** Y N
17. Is there anything you would like to speak to the Nurse about that is not on this list? Y N
18. If necessary, may the school nurse have your permission to contact your child's physician  
In regards to their health? Y N

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_