

# 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)]

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

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

Y N

1. Has been diagnosed with **ASTHMA**

2. Has had **SEIZURE** activity in the past 12 months.

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.

Specify: \_\_\_\_\_

5. Is allergic to **Bees/Wasps**

Specify: \_\_\_\_\_

Medication: \_\_\_\_\_

6. Is allergic to **Medication/Latex/Other**

Specify: \_\_\_\_\_

7. Allergic to foods

Food(s): \_\_\_\_\_

Reaction(s): \_\_\_\_\_

Medication: \_\_\_\_\_

8. Is **DIABETIC: TYPE I** \_\_\_\_\_ **TYPE II** \_\_\_\_\_

9. Wears glasses/Contacts

10. Has a hearing aid and/or hearing problems

11. Has specialized equipment:

(i.e. wheelchair, leg braces, assistive feeding devices, crutches, walker, catheterization, ostomy supplies, diabetic meters, etc.) Specify:

12. Has a diagnosis of **ADD/ADHD**

13. Has a diagnosis of **Depression**

14. Has a diagnosis of **Anxiety**

15. Has a diagnosis of **Manic Depression or Bipolar**

16. Has **Headaches/Migraines**

17. Is there anything you would like to speak to the Nurse about that is not on this list?

18. If necessary, may the school nurse have your permission to contact your child's physician in regard to their health?

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

Parent Name: \_\_\_\_\_