ASTORIA SCHOOL DISTRICT
STUDENT HEALTH QUESTIONNAIRE

Date:_____ Grade:_____ Teacher:_____

Name:_____ Date of Birth:___/___/___
Last First Middle

Healthcare Provider:_____ Date of last exam:_____

Dentist:_____ Date of last exam:_____

Circle the following conditions that pertain to student:

Allergies Yes No
To food, animals, drugs? Please list:_____
_____
Requires emergency medication? Yes No
List Medication:_____

Bee Sting Allergy Yes No
Describe reaction:_____
Difficulty breathing? Yes No
Need Emergency Medication? Yes No
List Medication:_____

Asthma Yes No
Triggered by?_____
Treatment:_____
Date diagnosed by doctor:_____

Diabetes Yes No
Take Insulin? Yes No
Date Diagnosed:_____

Epilepsy/ Seizures Yes No
Describe seizure:_____
Date of last seizure:_____
Currently under care of doctor? Yes No
List Medication:_____

Heart Condition Yes No
Describe:_____
Any physical restrictions?_____
List Medication:_____

Kidney/Bladder Problem Yes No
Chronic Infections? Yes No

Eyes Glasses/ Contacts
Date of last Exam:_____
Name of Vision Provider:_____
Other eye problems:_____

Ears
Difficulty Hearing Yes No Explain:_____
Hearing Aids Yes No Right/Left
Tubes Yes No Date inserted:_____

OVER

Mental/ Emotional Problems	Yes	No	Depression	Eating Disorder	Anxiety
			Phobias	Violent Behavior	ADHD
			Excessive Worry	Frequent Headache	ADD

Currently under doctor/counselor care? Yes No

Name of Mental Health Provider:_____

List Medications:_____

Other (Please describe):

Cancer: Site & Date Diagnosed:_____

Severe stomach pain or ulcers:_____

Blood Disorder:_____

Nose Bleeds:_____

Severe Head Injury/ Concussion- Date of Injury:_____

Bone/ joint problems:_____

Skin problems:_____

List serious illness/injuries/surgeries& date:_____

_____

List Daily Medications Below:

Medication	**Reason for taking**	**Dosage**	**Taken at home or school**

***If student requires medication at school, please obtain the appropriate forms from the school office.**

***A signed Authorization to Disclose Protected Health Information needs to be in student file before school staff may communicate with healthcare provider. Please see school counselor or nurse for appropriate form.**

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand that the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or urgent care clinic. I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered.

_____

Signature of Legal Parent/Guardian Telephone Contact # Date