PLAINVIEW ELGIN MILLVILLE SCHOOL DISTRICT STUDENT HEALTH SURVEY

Student Name _____ Teacher/**Grade** _____

Please provide the following information for the purpose of initiating or updating your son or daughter's school health record. **Please mail or bring the form back to the health office**. If your child received any recent immunizations, please provide a copy of the immunizations.

Please check any conditions which apply to your child:

- ❑ Allergies Triggers:_____ Treatment:_____
- ❑ Asthma Triggers: _____ Treatment: _____
- ❑ Attention Deficit/Hyperactivity Disorder Medication: _____
- ❑ Diabetes
- ❑ Emotional/Behavioral Concerns
- ❑ Headaches (severe or frequent)
- ❑ Heart condition
- ❑ Hearing impairment Hearing aids: Circle one Yes No
- ❑ Injuries (severe or which had lasting effects)
- ❑ Hospitalizations in the past (note reason below)
- ❑ Medication (on a regular basis-write name below)
- ❑ Orthopedic condition (bone or muscle)
- ❑ Physical activity limitations
- ❑ Seizure disorder Medication: _____
- ❑ Stomach/Abdominal/Intestinal Problems
- ❑ Special Diet Type: _____
- ❑ Surgical procedures in the past
- ❑ Vision impairment Wears glasses or contacts: Circle one Yes No
- ❑ Other conditions affecting your child's health (explain below)
- ❑ No health concerns

Please describe in further detail any condition which you checked above:

_____

_____

Person(s) who will make Health decisions for student if parent not available:

Name_____ **Phone**_____

Is there a need for parent/school nurse conference? Circle one Yes No

I give permission for this information to be shared with:

- ❑ Health Office Staff Only
- ❑ Classroom Teacher
- ❑ Any staff who may be responsible for my child.

Parent Signature _____ **Date** _____

Office Use Only Entered _____ Listed in concerns _____ Reviewed by LSN/RN _____