



SCHOOL HEALTH QUESTIONNAIRE UPDATE

Name of child: _____ Date of birth: _____ Grade: _____
School: _____ Name of person filling out questionnaire _____
Relationship to student _____ Name of doctor/clinic: _____

Insurance status: (Check one) **Currently Insured** **Medicaid** **No insurance** If no insurance or high deductible insurance, would you like information about medical resources in the community?
(Check one) **Yes** **No**

1. Does your child have a current health condition? No ___ Yes ___
(If yes, please indicate the name of the condition(s) and the doctor who cares for your child.)

Will your child need accommodations at school for this condition? No ___ Yes ___
(If yes, please describe what accommodations are necessary.)

2. Does your child take medication on a regular basis? No ___ Yes ___
(If yes, please provide the names and dosages of the medications.)

3. Does the medication need to be given at school? No ___ Yes ___
(If yes, please request a "Permission for Medication" form. Please note that the form must include a physician's order, including his/her signature.)

I grant permission for the above health information to be shared with adults who will be working with my child in the school setting.

Date: _____ Parent/Guardian signature: _____