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.

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Signature of Legal Parent/Guardian Telephone Contact # Date