TILLAMOOK School District #9 Teacher:_____ Grade:____

HEALTH QUESTIONAIRE

STUDENT'S NAME: _____ BIRTHDATE: _____ COUNTRY OF BIRTH: _____

STUDENT'S ADDRESS: _____ PHONE: _____ CELL: _____

☐ ***MY CHILD HAS A MEDICAL CONDITION WHICH MAY REQUIRE ATTENTION AT SCHOOL (MEDIC ALERT)***

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?	**CHOOSE ONE**
Hearing Problem	☐ NO ☐ YES
Speech Problem	☐ NO ☐ YES
Dental Problem	☐ NO ☐ YES
Has your child been seen by a dentist or dental hygienist in the past 12 months?	☐ NO ☐ YES
Vision Problem	☐ NO ☐ YES
Has your child been prescribed Glasses or contact lens?	☐ NO ☐ YES
Allergies ☐ Environmental (dust, etc.) ☐ Insect Allergy ☐ Food Allergy _____ ☐ Medicine Allergy _____	☐ NO ☐ YES
☐ Severe allergic reaction, that a doctor/nurse practitioner has prescribed an Epipen or Epipen Jr?	☐ NO ☐ YES
Diabetes (if yes, please indicate) ☐ Type 1 ☐ Type 2 ☐ Other	☐ NO ☐ YES
Digestive Problems (Ulcer, Colitis, Vomiting, etc.)	☐ NO ☐ YES
Heart Condition	☐ NO ☐ YES
If yes, what is the medical diagnosis?	
Asthma or Other type of breathing problem	☐ NO ☐ YES
Epilepsy or Seizure Disorder	☐ NO ☐ YES
If yes, what kind of seizures?	
Cancer – has your child ever been diagnosed with cancer?	☐ NO ☐ YES
If yes, what type of cancer? Is your child still being treated for cancer?	☐ YES ☐ NO
Headaches which are frequent or severe?	☐ NO ☐ YES
If yes, what helps your child when a headache occurs?	
Has your child had one or more previous head injuries or concussions?	☐ NO ☐ YES
If yes, when did this occur?	
Blood Disorder (Anemia, Hemophilia, Bleeding Disorder)	☐ NO ☐ YES
Cerebral Palsy	☐ NO ☐ YES
Orthopedic (Bone) Problem	☐ NO ☐ YES
Bowel or Bladder Problem	☐ NO ☐ YES
Kidney Problem	☐ NO ☐ YES
Skin Problem (eczema, hives, etc.)	☐ NO ☐ YES
If yes what type of skin problem?	
Special Diet	☐ NO ☐ YES
If yes, type of diet: _____ Only students with the appropriate medical documentation on file at school can have food substitutions in the school breakfast/lunch program.	
Learning Difficulties	☐ NO ☐ YES
If yes, please describe:	
Attention Deficit Disorder or ADHD	☐ NO ☐ YES
Does your child have any other health concerns not listed above?	☐ NO ☐ YES
If yes, please describe:	

****A medication form must be filled out for all medication taken during school.**

****To protect your child, this information will be shared with school staff working with your child.**

If you would like to speak to the health nurse regarding any special health needs your child may have, please leave a message at the school office or call the Tillamook County Community Health Center (TCCHC) at 503-842-3900.

Parent/Guardian Signature _____ **Date:** _____

☐ **NO MEDICAL CONCERNS**