Stewartville School District #534

Student Health Survey

STUDENT INFORMATION

Name: DOB Gender ◯ M ◯ F

School: Grade: Parent/Guardian Name:

Phone # (cell): Phone #: Email:

Primary Care Provider: Clinic Location:

HEALTH HISTORY **Check all conditions your child currently has or has been treated for in the past.**

	CONDITION:	EXPLAIN:
☐	Diabetes	
☐	Seizures	
☐	Allergies (triggers)	
☐	Asthma (triggers)	
☐	Lung/Respiratory Disease	
☐	Heart/Cardiovascular Conditions	
☐	Head Injury/Concussion	
☐	Behavioral or Emotional Difficulties	
☐	Neurological Disorders	
☐	Attention Disorders (ADD, ADHD)	
☐	Mental Health Conditions (e.g. anxiety,depression)	
☐	Fainting Spells and/or Dizziness	
☐	Kidney/Bladder Conditions	
☐	Ear/Eyes/Nose/Sinus Conditions	
☐	Muscle or Bone Conditions	
☐	Abdominal/Stomach/Digestive Problems	
☐	Migraines or Severe Headaches	
☐	Food Restrictions/Special Diet	
☐	Skin Conditions	
☐	Mobility Problems or Activity Restrictions	
☐	VISION CONCERNS	Glasses/Contacts: ◯ YES ◯ NO
☐	HEARING CONCERNS	Hearing Aids: ◯ YES ◯ NO ◯ Right Ear ◯ Left Ear ◯ Both Ears
☐	List any other medical conditions:	

MEDICATIONS **List all prescription, over the counter, and medications taken as needed (e.g., EpiPen, inhalers, pain relievers)**

Medication	Dose	Frequency	Reasons:

Would you like to schedule a conference with the Student Health Services Office to discuss a particular health concern? ◯ YES ◯ NO

Indicate your concern(s):

The information you provide will only be shared with school staff who require access to this information to meet your child's health and safety needs while at school and for off campus activities. Not providing complete and accurate information may result in an incomplete health and safety plan for your child.

Parent/Guardian signature: **Date:**

An electronic signature is allowed and certifies the information to be accurate.