NEW HOPE-SOLEBURY SCHOOL DISTRICT
School Health Services

Student Health Survey
Requested on Entry to School

Date:

Last Name: First Name: Middle Name:

Date of Birth: Grade Entering: ☐ MALE ☐ FEMALE

Parent/Guardian

Mother's Name: Day-time Phone: Cell Phone:

Father's Name: Day-time Phone: Cell Phone:

Dear Parent:
It is helpful for school personnel to understand your child's health status. Please take the time to answer ALL of the questions below. Thank you.

Student's Physician: Approximate date of last exam:

Student's Dentist: Approximate date of last exam:

1. Does your child wear corrective lenses for vision? ☐ NO ☐ YES

   If yes, describe type of correction:

2. Check any current health conditions listed below and provide specifics:

   ☐ Allergy(s) to:

   Describe reaction:

   Current Medications:

   Hospitalized for Acute Allergic reaction: ☐ NO ☐ YES Date(s):

☐ Asthma Triggers (causes for episodes): ______

Current Medications: ______

Hospitalized for Acute Asthma: ☐ NO ☐ YES Date(s): ______

☐ Diabetes Type: ______ When diagnosed: ______ Control Method: ______

☐ Epilepsy/Seizure Disorder Type: ______ When diagnosed: ______

Current Medications: ______

☐ Heart Condition Type: ______ Restrictions: ☐ NO ☐ YES

☐ Recurring Ear Infections Ear tubes: ☐ NO ☐ YES Currently with tubes: ☐ NO ☐ YES

☐ Visual Impairment: Describe: ______

☐ Hearing Impairment: Describe: ______

☐ History of Fainting: Explain: ______

☐ Frequent/Severe Headaches: Explain: ______

☐ Frequent/Severe Nosebleeds: Explain: ______

☐ Dietary Restrictions: Explain: ______

3. Disease History/Illnesses

Please place an approximate date next to all that apply:

Chicken Pox: ______ Lyme disease: ______ Kidney Disease: ______

Pneumonia: ______ Gastrointestinal: ______ Heart Condition: ______

Seizure: ______ Skin Disorder: ______ Bleeding Disorder: ______

ADD.ADHD: ______ Other Serious Illness or Injury: ______

Please provide additional information here: ______

4. Is your child under a doctor's care for a chronic illness or recent injury? ☐ NO ☐ YES

Explain:

5. Does your child have any condition which could be a school emergency? ☐ NO ☐ YES

Explain:

6. Is physical activity limited? ☐ NO ☐ YES

Explain:

7. Does your child have any emotional or social concerns we should be aware of? ☐ NO ☐ YES

8. Is your child taking any regular medication other than for asthma or allergies? ☐ NO ☐ YES

9. Please share any congenital conditions:

10. Does your child have any toileting issues? ☐ NO ☐ YES

11. Additional information that may be helpful concerning your child:

Signature:

Date: