



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

Guardian 1: Day-time Phone: Cell Phone:

Guardian 2: 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: