SILO IMMANUEL LUTHERAN SCHOOL STUDENT HEALTH SURVEY

Student Name _____ **Grade** _____

Please provide the following information for the purpose of initiating or updating your son or daugher's school health record. Please mail or bring the form back to the school health office.

General Health (circle) : Excellent Good Other (explain below)

Please check any conditions which apply to your child:

- ❑ Allergies Triggers: _____ Treatment: _____
- ❑ Asthma Triggers: _____ Treatment: _____
- ❑ Attention Deficit/Hyperactivity Disorder Medication: _____
- ❑ Diabetes
- ❑ Emotional/Behavioral Concerns
- ❑ Headaches (severe or frequent)
- ❑ Heart condition
- ❑ Hearing impairment Hearing aides: yes/no
- ❑ Hospitalizations in the past (note reason below)
- ❑ Injuries (severe or which had lasting effects)
- ❑ Medication (on a regular basis-write name below)
- ❑ Orthopedic condition (bone or muscle)
- ❑ Physical activity limitations
- ❑ Seizure disorder Medication: _____
- ❑ Stomach/Abdominal/Intestinal Problems
- ❑ Special Diet Type: _____
- ❑ Surgical procedures in the past
- ❑ Vision impairment Wears glasses or contacts: yes/no
- ❑ Weight concerns
- ❑ Other conditions affecting your child's health (explain below)
- ❑ NO Health Concerns

Please describe in further detail any condition, which you checked above:

_____

_____

Child's Doctor's Name/Clinic: _____

Is there a need for parent/school nurse conference? Yes/No

I give permission for this information be shared with:

- ❑ Health Office Staff Only
- ❑ Classroom Teacher
- ❑ Any staff who may be responsible for my child.

Parent Signature _____ **Date** _____

Office Use Only Entered _____ Listed in concerns _____ Reviewed by LSN/RN _____

Health Office
Tan