Howard County Public School System
Health Survey Form

Date: _____

Child's Name: _____ DOB: _____ Entering Grade: _____

Entering School: _____ Last School Attended with City/State: _____

HAS YOUR CHILD EVER ATTENDED A MARYLAND PUBLIC SCHOOL? **YES ____ NO ____**

Contact Information

Name of Person Giving Information: _____ Relationship: _____

What is the best phone number to reach you at while your student is at school? _____

Would you like to be contacted by email? If YES, please provide best email address _____

Can we reach you by text? If YES, please provide cell phone number _____

Medical Information

Does the student have:

- A Physician? **YES**: _____ Name and telephone number physician:_____
  NO: _____ Do you need help finding a physician? **YES ____ NO ____**
- Date of last Physical Exam: _____
- Date of last Dental Exam: _____
- Date of last Vision Exam: _____
- Health Insurance Coverage? **YES ____ NO ____**

Health History

1. Will the student require medication to be given at school? **YES ____ NO ____** _____
   If YES, a Medication Order Form must be completed for each prescription and over the counter medication to be given during school.
2. What medications are taken at home: _____

Medical Concerns:

Yes	No	
		a. Allergies? *(please list)* _____
		b. Is the NUT-FREE table required for this student? _____
		c. Medical Conditions? For example: ADHD, Diabetes, Seizures, Asthma, Cardiac, Blood Disorders, Cancer, etc. *(please list)* _____ _____
		d. Hospitalizations or Operations? *(please list)* _____ _____
		e. Physical Handicapping Conditions? *(please list)* _____
		f. Activity Restrictions? If yes, a Physical Education Activity Restriction form must be completed by a physician. _____
		g. Assistive Devices? *(please list)* _____
		h. Mental Health Issues? *(please list)* _____
		i. Speech Difficulties/Developmental Delays? *(please list)* _____
		j. Vision Difficulties? For example: Wears Glasses or Contacts, Crossed Eyes,, etc. *(please list)*_____ _____
		k. Hearing Difficulties? _____
		l. Any Other Health Concerns? For example: eating/sleeping habits, posture, skin/teeth, weight, daytime wetting/stooling concerns, etc. *(please list)* _____

HEALTH OFFICE USE ONLY: *Reviewed by (name & title)* _____ Date: _____ **Revised 6/12/15**