Howard County Public School System

SCHOOL HEALTH SERVICES
Health Survey Form

Date ___/___/_____

Child's Name _____ Date of Birth ___/___/_____

Entering School _____ Entering Grade _____

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 of 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*) _____

☐ Yes ☐ No **b. Is the NUT-FREE table required for this student?** _____

☐ Yes ☐ No **c. Medical Conditions?** For example: ADHD, Diabetes, Seizures, Asthma, Cardiac, Blood Disorders, Cancer, etc. (*please list*) _____

☐ Yes ☐ No **d. Hospitalizations or Operations?** (*please list*) _____

_____

☐ Yes ☐ No **e. Physical Handicapping Conditions?** (*please list*) _____

☐ Yes ☐ No **f. Activity Restrictions?** If yes, a Physical Education Activity Restriction form must be completed by a physician. _____

☐ Yes ☐ No **g. Assistive Devices?** (*please list*) _____

☐ Yes ☐ No **h. Mental Health Issues?** (*please list*) _____

☐ Yes ☐ No **i. Speech Difficulties/Developmental Delays?** (*please list*) _____

☐ Yes ☐ No **j. Vision Difficulties?** For example: Wears Glasses or Contacts, Crossed Eyes, etc. (*please list*) _____

_____

☐ Yes ☐ No **k. Hearing Difficulties?** _____

☐ Yes ☐ No **l. Any Other Health Concerns?** For example: eating/sleeping habits, posture, skin/teeth, weight, daytime wetting/stooling concerns, etc. (*please list*) _____

Health Room Use Only

Form **Received** - Date: ___/____/_____ Form **Reviewed** - Date: ___/____/_____

Signed: _____ Signed: _____

Return to the Health Room at your child's school.