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*) ______________________________

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❑ 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*) ______________

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❑ 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: ___/____/_________
Signed: ______________________________

Form **Reviewed** - Date: ___/____/_________
Signed: ______________________________

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