BROOKLYN MIDDLE SCHOOL

ANNUAL HEALTH QUESTIONNAIRE

_____________ SCHOOL YEAR

STUDENT NAME____GRADE___________

ADDRESS____PHONE#______________

1. Does your child have any medical conditions we should know about? If yes, please list.
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____

2. Please list any illness, injury or surgery your child had during the last year.
____
____

3. Does your child have any one of the following conditions? If yes, please specify.

Food Allergies NO YES ____________________________________
Bee Sting Reaction NO YES ____________________________________
Asthma Condition NO YES ____________________________________
Other Allergies NO YES ____________________________________

4. Please list any medications your child takes <u>daily</u>.
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5. Does your child wear glasses? NO YES
Does your child wear contact lens? NO YES
Does your child wear glasses/contacts for: Reading Distance Both

6. Does your child have a **documented** hearing difficulty? NO YES

7. May we share this information with the appropriate teachers? NO YES

8. Does your family have health insurance? NO YES

9. Additional comments: (include any other problems that you feel the school nurse should know).
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____
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Parent Signature ____Date ____________
(please circle response and return this form to the school nurse)