NEW LENOX SCHOOL DISTRICT 122
HEALTH SURVEY

______________________________ ______ ____________________
Student's Name Grade School

Please Check Yes or No: **Comments:**

YES **NO**

___ ___ Does your child take any medication at home? ___________________________
If yes, please list name and dose ___________________________
____

___ ___ Will your child take medication while at school? ___________________________
If yes, please list name and dose ___________________________
____

___ ___ Food Allergies (if yes, which foods and please give ___________________________
details of the reaction) ___________________________
___ ___ Other allergies (if yes, specify) ___________________________
___ ___ Does your child need an epipen at school for allergies? _______________________

___ ___ Does your child wear glasses or contacts? ___________________________

___ ___ Does your child have a history of ear problems? ___________________________
If yes, please provide details (tubes, hearing loss)

Has your child's doctor diagnosed him/her with the following:
___ ___ ADHD/ADD ___________________________

___ ___ Asthma (if yes, please answer the following): ___________________________
Exercise induced: Yes No ___________________________
My child will need an inhaler at school: Yes No ___________________________

___ ___ Seizure Disorder (if yes, what type) ___________________________

___ ___ Diabetes ___________________________

___ ___ Skin Condition (eczema, hives) ___________________________

___ ___ Bowel or bladder problems ___________________________

Please list any other health information that your child's teacher or school nurse should be aware of (i.e. surgery or serious illness):
____

____
I understand that the district will employ emergency medical services for my child if needed.

____________________________ ____________________________ ____________________
Parent/Guardian Signature Please Print Parent Name Date
Revised 01/07