

STUDENT HEALTH QUESTIONNAIRE

Student name: \_\_\_\_\_  
(Please print)

M / F Grade: \_\_\_\_\_  
(Circle one)

Does your child have:

	YES	NO
Allergies to food	_____	_____
Allergies to medication	_____	_____
Allergy to latex	_____	_____
Allergy to bee stings	_____	_____
Asthma	_____	_____
Diabetes	_____	_____
Seizure disorder	_____	_____
Heart problem	_____	_____
Neurological problem	_____	_____
Scoliosis	_____	_____
Surgery (recent)	_____	_____
Stitches (over summer)	_____	_____
Fractures (over summer)	_____	_____
Daily medication	_____	_____

Please explain all "Yes" responses:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Date of lead testing/results: \_\_\_\_\_

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Please initial in the space provided

\_\_\_\_\_ I give permission for the school nurse to release the above information to faculty or staff of Princeton Charter School for educational or safety purposes.

\_\_\_\_\_ I give permission for the school nurse to obtain pertinent medical information from my child's primary care physician. Examples include immunization record, health history, or medication information.

\_\_\_\_\_ I do **not** wish any of the above information to be released to staff other than the school nurse.

Parent Name: (please print) \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_