ANNUAL HEALTH SURVEY
Independent School District # 2909
Rock Ridge Public Schools

School Year ____ Grade/Teacher _____

Student's Name _____ Sex_____ Birthdate _____

Parent/Guardian's Name _____

_____ _____ _____ _____
Home Work Cell Cell

Address _____

Emergency Contact Person(s) with transportation who will care for child in case parent cannot be reached:

1. _____/ Phone _____ 2. _____/ Phone _____

Physician/Health Care Provider _____/ Phone _____

Does your child have any problems that may affect his/her learning or health in school, cause you any concern and/or are important for the school staff to know? <u>The nurse may share health concerns that will affect a student at school, with the teacher or other school staff, unless otherwise requested in writing</u>. Please check yes or no for each of the following items:

CONCERN	YES	NO	PLEASE SPECIFY
Health Concerns (ex: ADHD, Asthma, Vision, Hearing, Diabetes, Allergies, Headaches, Seizures, Etc.)			
Daily Medications at Home (Please List Medication name)			
Daily Medications at School (Name of medication, time to be administered, Complete Medication Administration Form)			
Health Precautions/Restrictions			
Has your child had any serious illnesses, surgery, accidents or hospitalizations this past year?			

Check if your child has any of the below noted health needs:
__ Asthma w/inhaler __Asthma w/nebulizer __Diabetes w/insulin __ Diabetes w/insulin pump __Emergency glucagon
__Seizure __Seizure w/emergency diastat __Hearing deficit/concern __ Vision deficit/concern __Bee/insect allergy
__Bee/insect allergy w/Benadryl __Bee/insect allergy w/Epi-Pen
__Food allergy to:_____ __ Food allergy w/Benadryl __Food allergy w/Epi-pen
__Physical limitation: _____
__ Allergy to medication/other agents: _____
__Medical condition that requires parent to be notified when (i.e.) chicken pox, 5th disease, measles, strep throat is diagnosed in other close contact students: _____

If your child received any immunizations this past year, please list below with the month, day, and year:
_____Tdap _____MMR _____ Hep B _____Polio _____Meningococcal _____Varicella _____Hep A

All medications needed for school must be provided by parents/guardians and the ISD #2909 Medication Authorization Form completed requiring physician and parent signature. This form is available in the nursing offices and on the school web site at rrps.org. In the event of Emergency our procedure will be to contact the parents at home or at work. When this is not possible an ambulance will be called. Your Emergency Contact person may be asked to care for your child until you can be reached.

Signature of Parent/Guardian _____ Date _____

PLEASE RETURN THIS SURVEY AS SOON AS POSSIBLE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR STUDENT'S SCHOOL NURSE