ROCK RIDGE PUBLIC SCHOOLS ANNUAL HEALTH SURVEY

School Year _____ Bus ____yes ____no Bus # _____ Grade/Teacher _____
Student's Name _____ Sex_____ Birth Date _____
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. If boxed conditions are in **BOLD** go to rrps.org under the school health tab and complete an Emergency Action Plan Form.
__ **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 under Health Forms. 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 THE SCHOOL NURSE AT 742-3918 THIS ANNUAL HEALTH SURVEY IS ONLY GOOD FOR THIS SCHOOL YEAR AND WILL BE DESTROYED AT THE END OF THE YEAR.