WATERFORD PUBLIC SCHOOLS
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Mr. Thomas W. Giard III
*Superintendent*

Mr. Craig C. Powers
*Assistant Superintendent*

# Annual Health Questionnaire

Information provided on this questionnaire will be shared with appropriate staff as stated in the *Family Educational Rights & Privacy Act* (FERPA). Please note there are two sides to this form.

Student's Name: ________________________________________ School ____________________ Grade ______

Student's Physician: ________________________________________________ Phone: _________________

Student's Dentist: ________________________________________________ Phone: _________________

Other (Specialists): ________________________________________________ Phone: _________________

Does your child have any of the following conditions? *If yes, please explain in detail.*

Food Allergies No ____ Yes (which)________________________________________________
Reaction ________________________________________________________________________________

Medication Allergies No ____ Yes (which)________________________________________________
Reaction ________________________________________________________________________________

Bee Sting Allergies No ____ Yes (reaction)______________________________________________

Latex Allergies No ____ Yes (reaction)______________________________________________

Other Allergies No ____ Yes (reaction)______________________________________________

Does your child have an EpiPen ordered from a physician? No______ Yes_______

What is the EpiPen for (which allergy)?______________________________________________________

Asthma No_____ Yes (reaction)______________________________________________

Inhaler No_____ Yes_______ Home, school or both___________________________

Diabetes No_____ Yes_______ Insulin?___________________________________________

Heart Condition No_____ Yes_______________________________________________________

Urinary Condition No_____ Yes_______________________________________________________

Skin Condition No_____ Yes_______________________________________________________

**PLEASE COMPLETE THE REVERSE SIDE**

Does your child have any of the following conditions? *If yes, please explain in detail.*

Speech Difficulties No_____ Yes_______________________________________________________

Hearing Difficulties No_____ Yes_______________________________________________________

Vision Difficulties No_____ Yes_______________________________________________________

Scoliosis No_____ Yes_____ Under Doctors Care?_______________________________

List any serious illness, injury or surgery your child has had during the past year:

List all medications, herbal preparations and vitamins your child takes routinely or on an emergency basis:

List any other medical information about your child you feel important to share with the School Nurse:

Does your child have health insurance? Yes______ No________

__________________________________ Printed name of Parent/Guardian

_______________________________ Telephone number

__________________________________ Signature of Parent/Guardian

________________________________ Date