SCHOOL DISTRICT OF SHIOCTON
STUDENT HEALTH SURVEY

This form is being given to each student attending the **Shiocton School District** for the purpose of identifying those who have a special health need which should be called to the attention of the faculty. Please complete each item.

Name_____ Grade_____

Immunizations received over the summer_____ Date Received_____

Sees Dentist Regularly	Yes	No	Asthma	Yes	No
Color Blind	Yes	No	Seizure Disorder	Yes	No
Wears Glasses/Contacts	Yes	No	Diabetes	Yes	No
Severe Headaches	Yes	No	Heart Disease	Yes	No
Blackout Periods/Dizzy Spells	Yes	No	High Blood Pressure	Yes	No
Hearing Difficulties	Yes	No	Any Activity Restrictions	Yes	No
ADHD	Yes	No	Allergies	Yes	No
Arthritis	Yes	No	If yes, explain_____		
Hay Fever/Seasonal Allergies	Yes	No	_____		
Reaction to Bee Stings	Yes	No	Hospitalized during the past 5 years	Yes	No
If yes, explain_____			If yes, explain_____		
Cancer	Yes	No	_____		

Indicate name and dosage of any prescribed or non-prescription medication your child is taking at **home**:

_____

List medication required during the **school day**: _____

Describe any special health concerns you may have regarding your child:

_____

Medications need to be provided by parents but there may be an urgent need or situation where a non-prescription medication was not supplied to the health office. The School District of Shiocton has my permission to give the following non-prescription medications in accordance with the dosage per age and weight of my child.

Acetaminophen	Yes	No	Topical Anti-itch Cream	Yes	No
Benadryl	Yes	No	Burn Relieving Gel	Yes	No

The School Nurse has my permission to share the above pertinent health information with teachers and other appropriate school personnel. As a parent or guardian, I will keep the district aware in writing of any changes in the medication profile or health concern of my child.

Signature of Parent or Guardian_____ Date_____

Updated 4/16