Warren County Technical School
2015 – 2016 Student Health History

Name: _____ Grade:_____

In order to best serve the medical needs of your son/daughter at Warren County Technical School, we ask for your cooperation in completing this questionnaire.

My child:

Yes/No Is currently taking medication: Name_____

Yes/No Is currently under a doctor's care:
Reason _____

Yes/No Has a medical problem/health condition of which school should be aware:

_____

Yes/No Has diabetes, if yes, needs to test blood sugars_____

Types and amount of insulin used daily_____

Yes/No Has asthma, If yes specify medications carried if applicable_____

Yes/No Has a seizure disorder, If yes, the name of medication used_____

Yes/No Wears eye glasses/contact lenses

Yes/No Has hearing impairment/uses aids

Yes/ No Has had surgery_____

Yes/No Has heart murmur, if yes, list restrictions_____

Yes/No Has allergies to:
Medications: _____
Insect/Bees: _____
Foods: _____
Other: _____
Type of reaction/treatment:_____

Yes/No I give my permission for the school nurse to share this information with my child's teacher(s).

Please list any other concerns_____

_____

_____ _____
Parent/Guardian Signature Date