SOLON SCHOOLS

STUDENT HEALTH QUESTIONNAIRE

BUILDING_____

Child's Name _____ Grade _____ Birth Date _____

Physician's Name _____ Dentist's Name _____

Medical History: Has your child had any of the following illnesses? If so, give approximate dates.

Chicken Pox _____ Measles (Rubeola) _____ German Measles _____

Mumps _____ Polio _____ Eczema _____ Asthma _____

Heart Condition _____ Rheumatic Fever _____

Frequent Colds _____ Sore Throats _____ Diabetes _____

Allergies: Foods _____

Bee Stings _____ Other _____

Explain symptoms & treatment _____

Is your child on medication? _____ Explain _____

Seizures _____ Explain _____

Hospitalizations (reasons & dates) _____

Serious illness or injuries _____

Orthopedic Problems _____

Ear Problems _____ Tubes _____

Hearing Difficulty _____ Speech Difficulty _____

Visual Problems _____ Explain Correction _____

Other health problems _____

_____

Has any member of the immediate family had one of the following?

Diabetes _____ Tuberculosis _____

Please bring your child's immunization record to the school office before your child enters school.

Parent Signature _____

Date _____

(1/13)