Wissahickon School District
School Health Services
Annual Health Survey*

To Parents or Guardian: The information requested on this form will be of help to the school nurse in determining the health status of your child and in assisting him/her to receive maximum benefits from the District Health Services. Please contact the Certified School Nurse if you have any questions.

Student's Name_____Sex_____Birthday_____Grade_____

Address _____Home Phone_____

During the past year, has your child: ***Please circle Yes or No***

Had an illness, serious injury, **concussion,** or operation? Yes No
If yes, give date and describe_____

Is student still under treatment? If yes, please give name of physician_____ Yes No

Does your child have any life threatening allergies? Yes No
If yes, to what?_____

Does your child have asthma? Yes No
If yes, what medications are used for treatment:_____

Is your child presently taking any medication(s)? Yes No
If yes, what kind(s) and for what reason? _____
Dosage required: _____Is it given daily or only when needed_____

Does your child require a special diet? If yes, please specify_____ Yes No

Does your child have any restriction from participating in physical education? Yes No
If yes, please explain_____

Does your child wear glasses or contact lenses? Yes No

Has your child had any immunizations during the past year? Yes No
If yes, what kind and date?_____ _____
Type of immunization Date given (month, day, year)
_____ _____
Type of immunization Date given (month, day, year)

Have there been changes in your family during the past year, such as:
Separation, divorce, or remarriage?_____ Yes No
Death or serious illness? Relationship to student?_____ Yes No
Any other situation which may affect your child?_____ Yes No

If your child has additional health concerns the school should be aware of, please list them below:
Please note if this condition might limit his/her activities in school. You acknowledge and consent that this information may be shared with persons that care for or supervise your child while at school or while transporting your child to and from school or during field trips.

_____ _____
Signature of parent or guardian Date

HA2 revised 6/14

To be completed by parents of all 2nd, 4th, and 8th grade students or when there is a change in health status