Annual Health Questionnaire
Plainfield Public Schools
(Information provided will be shared with appropriate staff as stated in the Family Education Rights and Privacy Act (FERPA)).

Student: ____________________________

Please answer (Y)es or (N)o to the following:

My child . . . . .

1. has fainted or blacked out Y N

2. has a family member who died suddenly or unexpectedly at a young age Y N

3. is prone to chest pain and/or shortness of breath during exercise Y N

4. has had seizure activity in past 12 Months Y N
   Specify: ____________________________
   Medications: ________________________________

5. received immunizations in the last 12 months Y N
   Specify: ________________________________

6. was seriously ill/sustained injury or had surgery in previous 12 months? Y N
   Specify: ________________________________

7. is allergic to bees/wasps Y N
   Specify reaction: ________________________________

8. is allergic to medicines Y N
   Specify: ________________________________

9. is allergic to pollen and/or mold Y N

10. has been diagnosed w/ asthma Y N

11. is allergic to foods Y N
    Food(s): ________________________________
    Reaction(s): ________________________________

12. is diabetic Y N

Date of Birth _______ Grade _______

13. takes medicine, vitamins or herbal supplements regularly Y N
    Specify: ________________________________

14. takes medicine, vitamins or herbal supplements for emergencies or when ill Y N
    Specify: ________________________________

15. wears glasses Y N
    □ for board work □ for reading □ all day
    (check all that apply)

16. has hearing aids Y N

17. has specialized equipment Y N
    (i.e. wheelchair, braces, assistive feeding devices, crutches, walker, catheterization supplies, ostomy supplies)
    Specify: ________________________________

18. has diagnosis of ADD/ADHD Y N

19. has diagnosis of depression Y N
    has diagnosis of anxiety Y N
    has diagnosis of manic depression or bipolar disorder Y N

20. has dental insurance Y N

21. has medical insurance Y N

22. Is there anything you would like to speak to the Nurse about that is not on this list? Y N

Parent/Guardian Signature ____________________________________________ Date __________________________

Phone ________________________________

(* Parent may provide other useful information on reverse of this form.)

Form #250