Norfolk Public School Department of Health Services

Student_____ Age____ Grade____ Teacher_____

Dear Parent: Please answer the following questions and return to the office or school nurse. This information will be helpful in providing health services and programs for our students. (Please check all that apply)

Allergies
[ ] Seasonal hay Fever
[ ] food
[ ] drugs
[ ] fumes
[ ] insect /bee stings
[ ] has bee sting kit
[ ] animals
[ ] other

[ ] Asthma

Blood Disorders
[ ] Anemia
[ ] Hemophilia
[ ] Leukemia
[ ] Frequent Nose bleeds[ ]
Other_____

Congenital Conditions
[ ] Orthopedic
[ ] Heart
[ ] Growth Disturbance
[ ] Down's Syndrome
[ ] Other_____

Eye Disorders
[ ] Severe visual impairment
[ ] Blindness
[ ] Glasses/Contacts
[ ] Other_____

Endocrine Disorder:
[ ] Diabetes
[ ] Hypoglycemia Problems
[ ] Thyroid Problems
[ ] Other_____

Hearing Problems:
[ ] Hearing loss
[ ] Frequent ear infections
[ ] Tubes in ears
[ ] Other_____

Neuromuscular Disorder:
[ ] Dizzy/ Fainting
[ ] Convulsions/Seizures
[ ] Frequent Headaches
[ ] Migraine Headaches
[ ] ADD/ADHD
[ ] Treated with Meds

[ ] Other_____

Stomach /Intestinal :
[ ] Constipation
[ ] Frequent Aches
[[Ulcer
[ ] Other_____

Other Conditions:
[ ] Skin Problems/eczema
[ ] Burns
[ ] Dental/Orthodontic
[ ] Scoliosis
[ ] Cancer
[ ] Speech Problems
[ ] Surgeries
[ ] serious injury
[ ] Other_____

If any of the above are checked, please explain the condition and how the school nurse can help your child:_____

_____

_____

Name of the doctor treating your child's condition: _____ Phone Number___ _____

Does your child take prescription medication on a regular basis? If so, Please give name of medication, dosage, and how often it is taken:

_____

_____

Did your child have any corrections during this summer vacation?

Change in eyes/fitted with glasses_____ Name of Eye Doctor _____

Ear Problems_____ Treatment_____

Dental Problems_____ Dentist_____

How is health care provided for this student?

[ ] Insurance [ ] Medicaid [ ] Kids Connection [ ] No Insurance [ ] Other

Medications will be administered at school with written parental consent. The medication must be brought to school in a proper prescription labeled bottle including (child's name, date, name of medication, dosage, and time to be given.) With request, the pharmacy will provide a duplicate "school" bottle. Non prescription medications will require a parental signature. Parent consent forms are available in the nurse's office or on the school website.

Your signature below grants permission to share this information with school personnel:

Date: _____ Parent/Guardian Signature:_____