# WELD RE-4 SCHOOL DISTRICT HEALTH SCREENING QUESTIONNAIRE-revised 12/10

Dear Parents/Guardians:

Please help us plan for your child's well being during school hours by completing this form carefully. Thank you.

Joni Heiden RN, School Nurse; Lisa Penate RN, School Nurse

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Student: _____ DOB: ___/___/___ Gender: M F School: _____

Grade next fall: _____ City and State of last school attended: _____

Name of person filling out questionnaire: _____ Relation to child: _____

1) When has your child last had a routine health exam: _____ By whom? _____

2) Does your child have any allergies? NO YES
If YES, list and explain type of reactions: _____

3) Does your child have any chronic health conditions? (Please circle which ones) asthma, diabetes, ulcers, seizure disorders, nervous conditions, frequent ear infections, strep infections, bronchitis, heart condition
Any other conditions? _____
If conditions exist: a. Is the student still under treatment? NO YES
b. Can school health services be helpful? NO YES
**If YES, please comment in detail:** _____

4) Has your child had any serious illness, operations, hospitalizations, or injuries—including head injuries, concussions, or loss of consciousness? NO YES Has your child been diagnosed with a traumatic brain injury? NO YES
If YES to either of above please explain: _____

5) Has your child had any problem with: Hearing? NO YES Vision? NO YES
Last exam for: Hearing: _____ By whom? _____
Vision: _____ By whom? _____

If YES to either hearing or vision problems, please explain: _____

6) Is your child on any medication? NO YES Reason prescribed: _____
If YES, list medication and directions: _____
Does medication need to be given in school? NO YES

**Medication can only be given in school with signed permission by doctor and parents.**
**Contact health room staff at your child's school or go to the district website, click on RE-4 Departments, then Health Services, and scroll to the bottom for a medication card.**

7) Does your child have any limitations or disabilities? NO YES
If YES, please explain: _____

8) Does your child have any need for special attention because of health problems? NO YES
If YES, please explain:_____

***I give my permission for the medical diagnosis to be shared with adults in the school setting that will be working with my child on a need to know basis.***

_____ _____

Signature of Parent/Guardian Date