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| **HEALTH SERVICES** | | **MEDICAL QUESTIONNAIRE FOR PARENTS** | |
|  | |  | |
| **SCHOOL YEAR** | **2022-2023** | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Student’s Name: |  | Date of Birth: |  |

Dear Parent:

|  |  |
| --- | --- |
| School records indicate your child has the following medical condition: |  |
|  |  |

Please provide the following information:

|  |  |
| --- | --- |
| How long has your child had this illness? |  |
| When was your child last seen for this condition? |  |
| Does your child currently take medication for this condition at home or school? If yes, please explain: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are there any physical activities your child should not participate in? | |  | Yes |  | No |
| If yes, please explain: |  | | | | |
|  |  | |  |  |  |

\*Please note: If your child is not to participate in physical education classes, a Physician’s note is

required.

|  |  |  |  |
| --- | --- | --- | --- |
| Physician’s Name |  | Phone: |  |
| Physician’s Address |  | Fax: |  |
|  |  |  |  |

|  |  |
| --- | --- |
| Please add any additional information needed to safely care for your child: |  |
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|  |  |
|  |  |

**IF YOUR CHILD IS NO LONGER BEING TREATED FOR THIS CONDITION AND YOU WOULD LIKE IT REMOVED FROM THE SCHOOL RECORDS, PLEASE SIGN BELOW AND RETURN TO THE SCHOOL NURSE.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Parent/Guardian Signature** |  | **Printed Name of Parent/Guardian** |  | **Date** |