



New Student Health Questionnaire

Child's Name: _____ Birth Date: _____ Grade: _____

An Individual Healthcare Plan (IHP) is necessary for students with asthma, diabetes, seizures, allergies, or other significant conditions. Forms are available on the district website or from the school health office.

1. Does your child have any severe / life threatening allergies? No Yes Explain: _____
Specify treatment needed at school: _____

2. Does your child have any mild / moderate allergies? No Yes Food? _____
Seasonal / environmental? _____
Other? _____
Specify treatment needed at school: _____

3. Does your child have asthma? No Yes How often? _____ Triggers: _____
Specify treatment needed at school: _____

4. Does your child have a history of seizures? No Yes What Type? _____ How often? _____
Actions to be taken at school: _____

5. Does your child have any cardiac / heart history? No Yes Explain: _____
Actions to be taken at school: _____

6. Does your child take any medications regularly? No Yes Where? at Home at School* Specify the medication, its purpose, dosage, frequency & other pertinent information: _____

* NOTE: Before any medications can be given at school, Med A or IHP forms must be completed by the parent/guardian and healthcare provider. See District website.

7. Does your child have any vision problems? No Yes Glasses? No Yes Contacts? No Yes
Specify problem(s) and treatment(s): _____

8. Does your child have any hearing problems or frequent ear infections? No Yes Which ear? Right Left Both
Specify problem(s) and treatment(s): _____

9. Does your child have any emotional / psychological concerns? No Yes Drug use? No Yes Self-injury? No Yes
Explain: _____
List any medications/drugs: _____
Actions to be taken at school: _____

10. Is there anything else about your child's medical, physical, or emotional health that you would like staff to know? _____

Authorization: I hereby authorize CCUSD 301 staff to release my child's health information / records to teachers, administration, transportation, sports coaches, and food service personnel for the purpose of treating or preparing for a medical situation for my child. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I prefer not to sign below, it will not interfere with my child's ability to obtain health care.

Name & Signature of Parent/Guardian: _____ Date: _____