Chandler Public Schools

General Health Questionnaire

Student's Name: ________________________________ Grade: _____________

Does your child have any of the following health problems?

Yes **No**

☐ ☐ Known Allergies

If **yes**, complete the following:

List allergens: ____

Does your child require an Epi-Pen? ☐ Yes ☐ No

☐ ☐ Asthma

If **yes**, does he/she require medication? ☐ Yes ☐ No

☐ ☐ Diabetes

If **yes**, ☐ Type 1 ☐ Type 2

☐ ☐ Epilepsy or history of seizures

Has your child had any hospitalizations, accidents, or serious illnesses in the past year? ☐Yes ☐No

If yes, explain: ____

Does your child have any chronic conditions that I should be aware of? ☐ Yes ☐ No

If yes, explain: ____

Does your child have any other medical or health problems I should be aware of? ☐ Yes ☐ No

If yes, explain: ____

Does he/she take medication on a daily basis? ☐ Yes ☐ No

Will he/she be taking medication at school? ☐ Yes ☐ No

If yes, please list below.

1. ___________________________________
2. ___________________________________
3. ___________________________________

Is your child under a physician's care? ☐ Yes ☐ No When was your child last seen? _____________

Physician Name: ______________________________________ Physician Phone: _____________________

Who do we contact in an emergency?

1. Name:_________________________ Relationship: __________________ Phone: _______________
2. Name: ________________________Relationship:__________________ Phone: _______________