HASBROUCK HEIGHTS PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Health History Questionnaire

To the parents or guardians of _____

It is important we have this information for your child's well-being during his/her school hours. Please complete and return this form to the School Nurse as soon as possible.

1. Does he/she have a medical Problem? If yes, please state problem:

_____

_____

_____

_____

_____

2. Is he/she on medication? If yes, pleas list medication(s):

_____

_____

3. Are there any restrictions? If yes, please list restrictions:

_____

_____

4. Does your child have any allergies to food or medication? If yes, what:

_____

_____

This information will be shared with staff as necessary. If you DO NOT want this information shared, please notify me immediately. Thank you for your cooperation in this matter.

Parent Signature:_____ Date: _____

UPDATED 1/23/09