CENTRAL DAUPHIN SCHOOL DISTRICT
SCHOOL HEALTH SERVICES DEPARTMENT
ANNUAL HEALTH SURVEY

TO PARENTS OR GUARDIAN: The information requested on this form will be of help to the school nurse in determining the health status of your child and in assisting him/her to receive maximum benefits from his/her educational opportunity. Please feel free to contact the nurse if you have any questions to discuss, or information you wish to share.

Parents please note: Certain information may be shared with other school staff members when the Certified School Nurse deems it necessary for the health and safety of the student. A parent will need to make your child's bus driver aware of any medical concerns.

Please return this form to your School nurse as soon as possible!

Student's Legal Name_____________________________ Grade ____Room____ Class Section _________

Physician's Name ________________________________ Phone #________________________

During the past year has your child:

Had an illness, serious injury or operation? Yes No

If yes, please describe it. ____

Is your child still under treatment? Yes No

If yes, name physician ____

Should your child be restricted from participating in school sports or gym? Yes No

If yes, please provide recommendations from your physician in writing.

Does your child have any life threatening allergies which require medical attention at school? Yes No

These allergies **MUST** be documented with a physician's order for the treatment of allergic reactions, especially bee stings and food allergies.

Is your child presently taking medication? Yes No

What kind: Dosage required: For what reason: When medication first started:

____

____

____

NO MEDICATION IS ADMINISTERED BY SCHOOL PERSONNEL UNLESS SPECIFIC WRITTEN INSTRUCTIONS ARE RECEIVED FROM A PHYSICIAN. (This applies to prescription and nonprescription oral and/or topical medications as well.)

If your child has had any immunizations this past year, please attach a copy of the updated immunization record from your physician.

Have there been any changes in your family during the past year, such as:

Separation, divorce or remarriage? ____ Yes No

Death or serious illness?____ Yes No

If your child has additional health problems the school should know about, please list them below:

____

____

____

Date _____________ Signature of Parent or Guardian ____

DPS 112 (5/12)