School Year 20_____/ 20_____

Annual Health Questionnaire
Plainfield Public Schools
(Information provided will be shared with appropriate staff as stated in the Family Education Rights and Privacy Act (FERPA).

Student: _____ Date of Birth: _____ Grade: _____

Please answer (Y)es or (N)o to the following:
My child…..

1. has fainted or blacked out. Y ☐ N ☐
2. has a family member who died suddenly or unexpectedly at a young age Y ☐ N ☐
3. is prone to chest pain and/or shortness of breath during exercise Y ☐ N ☐
4. has had seizure activity in the past 12 months Y ☐ N ☐
   Specify: _____
   Medications: _____
5. received immunization is the last 12 months Y ☐ N ☐
6. was seriously ill/sustained injury or had surgery in previous 12 months? Y ☐ N ☐
   Specify: _____
7. is allergic to bees/wasps Y ☐ N ☐
   Specify: _____
8. is allergic to medicines Y ☐ N ☐
   Specify: _____
9. is allergic to pollen and/or mold Y ☐ N ☐
10. has been diagnosed with asthma Y ☐ N ☐
11. is allergic to foods Y ☐ N ☐
    Food(s): _____
    Reaction(s): _____
12. Is diabetic Y ☐ N ☐
13. takes medicine, vitamins or herbal supplements regularly Y ☐ N ☐
14. takes medicine, vitamins or herbal supplements for emergencies or when ill Y ☐ N ☐
    Specify: _____
15. wears glasses Y ☐ N ☐
    ☐ For boardwork ☐ or reading ☐ all day
    (check all that apply)
16. has hearing aids Y ☐ N ☐
17. has specialized equipment Y ☐ N ☐
    (i.e.: wheelchair, braces, assistive feeding devices, crutches, walker, catheterization supplies, ostomy supplies)
18. has diagnosis of ADD\ADHD Y ☐ N ☐
19. has diagnosis of depression Y ☐ N ☐
    has diagnosis of anxiety Y ☐ N ☐
    has diagnosis of manic depression or bipolar disorder Y ☐ N ☐
20. has dental insurance Y ☐ N ☐
21. has medical insurance Y ☐ N ☐
22. is there anything you would like to speak to the nurse about that is not on this list? Y ☐ N ☐

_____ _____ **Phone:** _____
Parent/Guardian Signature **Date**

(*Parent may provide other useful information on reverse of this form.)

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