Weld County School District 6
1025 NINTH AVENUE | GREELEY, COLORADO 80631
970-348-6000 | WWW.GREELEYSCHOOLS.ORG

STUDENT SUPPORT SERVICES

Health Services

Returning Elementary & All 6th-12th graders - STUDENT HEALTH QUESTIONNAIRE

Name of Child____ Today's Date:__________ Grade:______ Teacher________________

Date of Birth_______________ Age______ Sex_______ Rides School Bus?_________ School______________________________

Parent/Guardian Name:____ Phone Number(s)__________________________________

Parent/Guardian Name:____ Phone Number(s)__________________________________

Primary Physician Name:_________________________ Date of last visit____________ Results:_____________________________

Specialist Physician Name:_______________________ Date of last visit____________ Results:______________________________

Dentist Name:___________________________ Date of last visit_____________ Results:__________________________________

Mental Health Therapist Name:____Date started:__________ Date of last visit:________

Medical Insurance Name:____**OR** Medicaid______ **OR** CHP+______ **OR** None______

HEALTH PERMISSIONS (PARENT MUST COMPLETE THIS SECTION - circle yes/no on ALL & sign/date)

Yes / No I give permission for my child to be treated with **Acetaminophen** (non-aspirin) for pain or fever.

Yes / No I give permission for my child to be treated with the following approved **non-prescription first aid** items: cortisone ointment, liquid antacid (age 12 and over), anti-bacterial soap and alcohol for cleansing, antibiotic ointment, Carmex and Vaseline for dry lips, eucerin cream, lotion, salt water gargle, Ora-gel. (If you object to the use of any of these items, please send a note to your child's school nurse stating why the medication is to not be used. Otherwise we will interpret this as permission to all mentioned above.)

Yes / No I give permission for the health office to **share health information** with school personnel on a need to know basis.

Parent/Guardian Signature ____ Date ___________________

1. Please list any medical diagnoses, vision, hearing, speech, dental, learning, social or mental health concerns for your child PAST or PRESENT (include age/date diagnosed and doctors if possible).________________________________
   ____

2. **Medical history**. In the past several years, please comment on any physical OR mental health concerns for your child.
   - Any illness? Yes____ No____ If yes, please explain____
   - Any injuries? Yes____ No____ If yes, please explain____
   - Any surgery/hospitalizations? Yes____ No____ If yes, please explain_________________________________
   - Has Child been seen in the Emergency room/Urgent Care? Yes___ No___ If yes, please explain_____________
   - Mental health concerns and/or therapy? Yes____ No____. If yes, please explain_________________________

3. **Allergies:** (food, medication, environment)? Yes____ No____. If yes, please describe reactions and severity ______
   ____
   - If your child has allergies, do they take antihistamine or epi-pen for treatment of reactions? Yes_____ No_______

4. **Medications:** Please list medications taken (past/present), dosage, and when taken:________________________________
   ____
   - Will your child need any daily medication or rescue/emergency medication at school? Yes_____ No_____. (If yes, please contact school health clerk to obtain physician authorization forms for medications at school).

5. Does child have: Hearing Aids:____ Orthodontic braces/appliances_____ Assistive devices/equipment________________
   Physical disability_____ Learning disability_____ . Please explain details and any limitations of activities:______________
   ____

6. Please describe concerns discussed at last dental AND physician appointments for your child. __________________
   ____

7. Has your child ever had any of the following? Speech/Language Therapy______ Occupational Therapy______
   Physical Therapy______ Mental Health Therapy_______ Behavioral Concerns_______ Other________________

8. If you would like to talk to the school registered nurse consultant, please contact your school's health office.