Cabot Public Schools
CONFIDENTIAL HEALTH QUESTIONNAIRE

Student: _____ Date of Birth: _____ Gender (Circle) Male Female

ALERT TO PARENTS: IF YOUR CHILD HAS A SERIOUS MEDICAL CONDITION, IT IS VITAL THAT YOU DISCUSS IT WITH THE SCHOOL NURSE IMMEDIATELY. IT IS VERY IMPORTANT THE SCHOOL BE AWARE OF **LIFE THREATENING** CONDITIONS.

Medical History: Check the conditions that apply to your child and describe under Comments.

___ ADD/ADHD	___ Cerebral Palsy	___Hearing problem	___ Seizures
___ Anxiety/Panic attack	___ Diabetes	___ Kidney/Urinary problem	___ Spina Bifida
___ Asthma	___ Epi-Pen	___ Lung condition	___ Vision problem
___ Bee Sting Allergy	___ Emotional concerns	___ Muscle disorder	___ Other (explain)
___ Behavior problem	___ Food Allergy	___ Neurological problem	
___ Bowel Problem	___ Headaches	___ Orthopedic problem	

Comments _____

Does your child wear glasses? _____ Contact lenses? _____ Hearing aids _____

Does your child have Health Care Insurance? Yes _____ No _____ Name of Provider _____

Do you have dental insurance? If yes, specify dental plan _____

Does your child have an Ongoing Source of Continuous and Accessible Dental Care? (Dental Home) Yes ____ No ____

Dentist Name _____ Date of last visit _____

Were there any problems for your child? _____

Allergies: List your child's allergies, reactions, and the treatment needed for reactions:

☐ Environmental allergies _____

☐ Food Allergies _____

☐ Insect/Bee sting allergies _____

☐ Allergy to Medications _____

Medications at Home or School: (Prescription, over-the-counter, and herbal* medicines)

Name/Dose/Time	Reason	Taken at School?	
1.		Yes	No
2.		Yes	No
3.		Yes	No
4.		Yes	No
5.		Yes	No

***** The Cabot School District policy regarding MEDICATION at school is in the Student Handbook.

ALL medication must be kept in the Health Room. NO medication can be given without a Medication Form which can be obtained in the school office.

Health Screenings: The Cabot School District conducts the following Health Screenings at the indicated grade levels as mandated by the state of Arkansas. **Please initial each line.**

Vision and Hearing (required per grant)	Pre-K, Kindergarten and grades 1, 2, 4, 6, 8 and Transfers	
Height and Weight (BMI, Act 1220)	All grades	
Dental (required per grant)	Pre-K	

Names of Physician: _____ Phone: _____

Preferred Hospital: _____

Release of Information: I give my permission for this information to be shared with school staff and Emergency Medical Personnel on a need to know basis during the current school year.

Parent/Guardian Signature: _____ Date: _____