# 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: _____