

Health Questionnaire

Student's Name _____ **Date of Birth** _____

I. Does your child have any health problems or concerns the Latchkey Personnel should be aware of?

If yes, what? _____

II. Is your child under a Doctor's care on an ongoing basis? _____

III. Has your child had surgery? (Example: ear tubes, eye surgery, tonsillectomy, etc.) _____

IV. Does your child take any medication regularly? _____

Name of Meds _____ Amount taken _____ How often _____

Name of Meds _____ Amount taken _____ How often _____

Name of Meds _____ Amount taken _____ How often _____

V. Does your child have any allergies-either food or environmental? Specify please. _____

VI. Does your child wear glasses? _____

Contacts? _____

Parent/Guardian's Signature

Date