Medical/Health Needs: Questionnaire for Parents-0716

To the Parent(s) of: __________________________________ Date: ____________________________

Our records indicate that your child has a medical/health condition. We need your answers to the following questions in order to better identify and determine how to address your child’s needs in the school setting. Please complete this questionnaire and return it to the school office as soon as possible. We will not take any further action relative to your child's health/medical needs until we receive this questionnaire from you.

1. What is your child specific medical/health condition? ____________________________________________

2. Has the medical/health condition been diagnosed by a doctor?  ____No  ____Yes

3. Has your child ever required emergency treatment as a result of this medical/health condition?  ____No  ____Yes; explain: __________________________________________________________

4. When having a medical/health emergency, what symptoms does your child experience? Check all that apply:

   - Stomach ache  
   - Abdominal cramps  
   - Hacking cough  
   - Diarrhea  
   - Vomiting  
   - Tightness in throat  
   - Rash  
   - Hives or swelling  
   - Shortness of breath  
   - Itching  
   - Loss of motor control  
   - Wheezing  
   - Nausea  
   - Sleepiness  
   - Loss of consciousness  
   - Other (explain): ________________________________________________________________

5. Are you requesting that the school provide any accommodations due to your child’s medical/health condition? Please be aware that any accommodations beyond oral or topical medications and basic first aid will require further documentation from your child’s physician. Please check any accommodations that you would like us to consider for your child:

   - ____No accommodations are necessary in the school setting.
   - ____Administer oral medication or topical medication (i.e., cream applied to skin)
   - ____Administer medication via injection (i.e., EpiPen, insulin, etc.)
   - ____Administer medication rectally
   - ____Restrict your child’s outdoor activities
   - ____Special transportation/bus considerations
   - ____Monitor or restrict the food your child eats
   - ____Monitor or restrict the food others eat in your child’s presence
   - ____Provide special seating arrangements in class, on bus, at lunch, etc.
   - ____Develop a written health management and/or emergency treatment plan
   - ____Other; explain: ________________________________________________________________

Parent Signature: __________________________ Date: __________________________

For school office use only:

   - ____No further action recommended; send notification letter to parent.
   - ____Obtain “Authorization for Administering Prescription Medication” from physician.
   - ____Obtain signed release to communicate with the student’s physician and develop health care/emergency plan.
   - ____Refer for 504 evaluation/plan; send a signed copy of this form to the Office of Special Services.

Signature of Building Administrator: __________________________ Date: __________________________