

Queen of Peace High School
Confidential Student Health Survey 2010/2011

Please take a moment to accurately complete this form. If you have questions or concerns about your daughter's health, please contact the school nurse for a confidential conference.

Student's Name _____ Phone (H) _____
 Entering grade _____ ID # _____ Birthdate _____ Name of Local Doctor _____

Condition	Yes	No	Comments
ADD/ADHD			Medication:
Allergies - Food			
Allergies - Insect			
Allergies-Medicine			
Anxiety			
Asthma			Medication:
Birth Defects			
Bone or Joint Problems			
Depression/Mood Disorder			
Diabetes			Medication:
Ear/Hearing Problems			
Frequent Headaches			
Glasses/Contacts			Last Eye Exam:
Eye Problems			
Heart Problems			
Hospitalization			
Surgery			
Medications			Please List::
Physical Restrictions			Please List::
Seizures			Medication:
Serious Injury			
Skin Disorders			
Stomach Problems			Medication:
Other			Please Describe:

If you answered yes to any of the above questions or your child has a condition not listed above, please describe in detail below. If your child requires medication during school hours, please refer to the medication policy in the student handbook. Please contact the Nurse's Office for concerns or any health changes throughout the year.

In order to foster growth and autonomy, please encourage your daughter to privately speak with her teachers regarding health concerns. Appropriate information may be shared with your daughter's teachers in order to assist in providing an optimal learning environment.

 Parent/Guardian Signature Phone #