

Queen of Peace High School
Confidential Student Health Survey 2009/2010

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 #