NEW STUDENT HEALTH QUESTIONNAIRE

Student Name:_____ Date of Birth:_____ Grade in 2017-18: _____

In order to assure the health and safety of your child at school, please complete the following questionnaire to assist us in identifying any health needs your child may have. **This should also serve as a tool for you to identify forms that are required to be on file with Pine Lake. Forms should be completed in cooperation with your child's physician and returned to the nurses, Rebecca Long and/or Alex Larson, by the first day of school each academic year.** Forms are also required for non-prescription medication administration, and Potassium Iodide administration in the event of a nuclear emergency.

Please note all needed forms may be accessed via pinelakeprep.org or may be obtained from the school nurse. On pinelakeprep.org, from the Home Page, click on the "Parents" tab. From the dropdown menu, choose "Forms/Documents". For questions or further information please contact Rebecca Long, RN, at rebecca.long@pinelakeprep.org.

My child has been diagnosed with the following by a physician, and I am providing documentation on specifics of their diagnosis from their physician:

1. **Asthma** [ ] Yes [ ] No (If yes, please answer questions below. If no, please proceed to #2)
   - Medication Required at school (including "as needed" medication) [ ] Yes [ ] No
   - Prescription and/or Non-prescription Medication form complete and turned in to school nurse [ ] Yes [ ] No
     Medication name _____
   - Asthma Action Plan completed and turned into school nurse [ ] Yes [ ] No
     (If no, plan is due by first day of school)

2. **Food Allergy** [ ] Yes [ ] No (If yes, please answer questions below. If no, please proceed to #3)
   Allergy to: _____
   - Medication required at school (including "as needed" medication) [ ] Yes [ ] No
     Medication name_____
   - Prescription and/or Non-prescription Medication form complete and turned into school nurse [ ] Yes [ ] No
   - Food Allergy Action Plan completed and turned into school nurse [ ] Yes [ ] No
     (If no, plan is due by first day of school)

3. **Bee Sting Allergy** [ ] Yes [ ] No (If yes, please answer questions below. If no, please proceed to #4)
   - Medication required at school (including "as needed" medication) [ ] Yes [ ] No
     Medication name _____
   - Prescription and/or Non-prescription Medication form complete and returned to school nurse [ ] Yes [ ] No

- Bee Sting Allergy Action Plan completed and returned to school nurse [ ] Yes [ ] No
  (If no, plan is due by first day of school)

4. **Fire Ant Allergy** [ ] Yes [ ] No (If yes, please answer questions below. If no, please proceed to #5)
   - Medication required at school (including "as needed" medication) [ ] Yes [ ] No
     Medication name _____
   - Prescription and/or Non-prescription Medication form
     complete and returned to school nurse [ ] Yes [ ] No
   - Fire Ant Allergy Action Plan completed and returned to school nurse [ ] Yes [ ] No
     (If no, plan is due by first day of school)

5. **Latex Allergy** [ ] Yes [ ] No (If yes, please answer questions below. If no, please proceed to #6)
   - Medication required at school (including "as needed" medication) [ ] Yes [ ] No
     Medication name _____
   - Prescription and/or Non-prescription Medication form complete
     and returned to school nurse [ ] Yes [ ] No

6. **Other Allergy** [ ] Yes [ ] No (If yes, please answer questions below. If no, please proceed to #7)
   - Allergy to _____

   - Medication required at school (including "as needed" medication) [ ] Yes [ ] No
     Medication name _____
   - Prescription and/or Non-prescription Medication form complete
     and returned to school nurse [ ] Yes [ ] No
   - General Allergy Action Plan completed and returned to school nurse [ ] Yes [ ] No
     (If no, plan is due by first day of school)

7. **Diabetes** [ ] Yes [ ] No (If yes, please answer questions below. If no, please proceed to #8)
   - Medication required at school (including "as needed" medication) [ ] Yes [ ] No
     Medication name _____
   - Prescription and/or Non-prescription Medication form complete
     and returned to school nurse [ ] Yes [ ] No
   - Diabetic Care Plan completed and returned to school nurse [ ] Yes [ ] No
     (If no, plan is due by first day of school)

8. **Seizures** [ ] Yes [ ] No (If yes, please answer questions below.)
   - Medication required at school (including "as needed" medication) [ ] Yes [ ] No
     Medication name _____
   - Prescription and/or Non-prescription Medication form complete
     and returned to school nurse [ ] Yes [ ] No
   - Seizure Action Plan completed and returned to school nurse [ ] Yes [ ] No