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:* ______________________