

**SCHOOL DISTRICT OF NEW LONDON
ANNUAL STUDENT HEALTH SURVEY**

Name: _____ Grade: _____ School: _____

My child is taking the following **prescription medication(s)**: _____ Dosage: _____

This medication needs to be taken by my child: at home at school

****Medication(s) must be supplied to school in the current prescription bottle with all medication information on the label along with a medication consent form signed by the parent/guardian AND the physician. This must be on file before the medication can be administered at school.****

My child is taking the following **non-prescription medication(s)**: _____ Dosage: _____

This medication needs to be taken by my child: at home at school

****Medication(s) must be supplied to school in the original, unopened bottle with medication ingredient list along with a medication consent form signed by the parent/guardian. This must be on file before the medication can be administered at school.****

My child has the following allergies: Medication Food Seasonal allergies Other, please specify _____

My child has been hospitalized during the past year for the following reason(s): _____

My child had the following communicable disease(s) in the past year: _____

My child had the following serious injury(ies) in the past year: _____

My child has the following activity restrictions: _____

My child has the following health issue(s): Asthma Seizures Diabetes Bee Sting Reaction

Food Allergy Reaction Other, please specify and explain _____

****Be sure to complete the corresponding care plan and medication consent form(s)****

Describe any special health concerns you may have regarding your child: _____

My child has received the following immunization(s) **over the past year**:

Vaccine: _____ Dose#: _____ Date: _____

Vaccine: _____ Dose#: _____ Date: _____

Vaccine: _____ Dose#: _____ Date: _____

Vaccine: _____ Dose#: _____ Date: _____

Vaccine: _____ Dose#: _____ Date: _____

OR my child had chickenpox on (date) (**documentation of diagnosis by a qualified health care provider is needed**):

It is the parent's/guardian's responsibility to provide school with current immunization records/waivers.

None of the above statements pertain to my child.

The school health program/health office/office is not legally responsible, nor is it equipped or staffed to provide extended care for ill students.

The School District Nurse has my permission to share health information with teachers and other school personnel who have a need to know.

Parent or Guardian Initials: _____

Date: _____

Initials will serve as your signature.