Cabot Public Schools
CONFIDENTIAL HEALTH QUESTIONNAIRE

Student: _____ Date of Birth: _____ Gender (Circle) Male Female

ALERT TO PARENTS: IF YOUR CHILD HAS A SERIOUS MEDICAL CONDITION, IT IS VITAL THAT YOU DISCUSS IT WITH THE SCHOOL NURSE IMMEDIATELY. IT IS VERY IMPORTANT THE SCHOOL BE AWARE OF LIFE THREATENING CONDITIONS.

Medical History: Check the conditions that apply to your child and describe under Comments.

___ ADD/ADHD	___ Cerebral Palsy	___Hearing problem	___ Seizures
___ Anxiety/Panic attack	___ Diabetes	___ Kidney/Urinary problem	___ Spina Bifida
___ Asthma	___ Epi-Pen	___ Lung condition	___ Vision problem
___ Bee Sting Allergy	___ Emotional concerns	___ Muscle disorder	___ Other (explain)
___ Behavior problem	___ Food Allergy	___ Neurological problem	
___ Bowel Problem	___ Headaches	___ Orthopedic problem	

Comments _____

Does your child wear glasses? _____ Contact lenses? _____ Hearing aids _____

Does your child have Health Care Insurance? Yes _____ No _____ Name of Provider _____

Do you have dental insurance? If yes, specify dental plan _____

Does your child have an Ongoing Source of Continuous and Accessible Dental Care? (Dental Home) Yes ____ No ____

Dentist Name _____ Date of last visit _____

Were there any problems for your child? _____

Allergies: List your child's allergies, reactions, and the treatment needed for reactions:

☐ Environmental allergies _____

☐ Food Allergies _____

☐ Insect/Bee sting allergies _____

☐ Allergy to Medications _____

Medications at Home or School: (Prescription, over-the-counter, and herbal* medicines)

Name/Dose/Time	Reason	Taken at School?	
1.		Yes	No
2.		Yes	No
3.		Yes	No
4.		Yes	No
5.		Yes	No

* The Cabot School District policy regarding MEDICATION at school is in the Student Handbook.
ALL medication must be kept in the Health Room. NO medication can be given without a Medication Form which can be obtained in the school office.

Health Screenings: The Cabot School District conducts the following Health Screenings at the indicated grade levels as mandated by the state of Arkansas.

Please initial each line.

Vision and Hearing (required per grant)	Pre-K, Kindergarten and grades 1, 2, 4, 6, 8 and Transfers	
Height and Weight (BMI, Act 1220)	All grades	
Dental (required per grant)	Pre-K	

Names of Physician: _____ Phone: _____

Preferred Hospital: _____

Release of Information: I give my permission for this information to be shared with school staff and Emergency Medical Personnel on a need to know basis during the current school year.

Parent/Guardian Signature: _____ Date: _____