JIM THORPE AREA SCHOOL DISTRICT
ANNUAL HEALTH SURVEY

TO PARENTS OR GUARDIANS: The information requested on this form will be of help to the school nurse in determining the health status of your child and in assisting him/her to receive maximum benefits from his/her educational opportunity. Information may be shared with school staff/teachers as necessary. Please feel free to contact the nurse if you have any questions or to discuss any health concerns.

STUDENT'S NAME _____ GRADE: _____
FAMILY DOCTOR _____ TELEPHONE: _____

(Circle One)

During the past year, has your child:
- Had an illness, serious injury, hospitalization or operation? Yes No
  - If yes, please describe it _____
- Is your child still under treatment? Yes No
  - If yes, name doctor _____

Should your child be restricted from participating in school sports or gym? Yes No
- If yes, please provide recommendations from your doctor in writing

Does your child require a special diet? Yes No
- If yes, please specify _____

Does your child have any allergies which require attention at school? Yes No
- If yes, please list _____

Is your child allergic to bee (or other insect) stings? Yes No
- If yes, a School Insect Sting Record will be sent to you

Does your child have asthma? Yes No
- If yes, a School Asthma Record will be sent to you

Does your child take epileptic seizures? Yes No
- If yes, please describe _____
  - list medication _____

Is your child presently taking medication? Yes No
- If yes, please name _____
  - for what condition? _____
  - how long has child been taking medication? _____

Does your child need to take medication during school hours? Yes No
- If yes, an Authorization for Medication form will be sent to you
- Also, please read information in Student/Parent Handbook

Does your child wear glasses or contact lenses? Yes No

Does your child have a hearing problem? Yes No

Has your child had any immunizations during the past year? Yes No
- If yes, please fill in the dates on the back of this page

Have there been any changes in your family during the past year, such as:
- Separation, divorce, or remarriage? Yes No
- Death or serious illness? Yes No
- Or any other situation which may effect your child? Yes No
  - If yes, please explain _____

Does your child have any emotional problems? Yes No
- If yes, please describe _____

List any additional health problems the school nurse should know about:

_____

_____

_____ _____

Signature of parent or guardian Date

Mailing address _____

If your child has had any of the following immunizations WITHIN THE PAST YEAR, please list the date(s).

IMMUNIZATIONS:		DATE:
Diphtheria and Tetanus (DTaP, DTP, Td or DT)		_____
Tetanus		_____
Polio (OPV or IPV)		_____
Measles, Mumps, Rubella (MMR)		_____
Varicella (Chicken Pox)		_____
Hepatitis B Series	#1	_____
	#2	_____
	#3	_____
Tuberculosis TB)		_____
Others: _____		_____
_____		_____
_____		_____