ST JOHNS CLASSICAL ACADEMY

SCHOOL HEALTH SERVICES

SCHOOL YEAR _____

HEALTH CONDITION QUESTIONNAIRE

(MUST BE FILLED OUT COMPLETELY BY PARENT)

PLACE PHOTO HERE

Name: _____ DOB: _____

Grade: _____ Teacher: _____ Allergies: _____

Parent: _____ Primary Phone Number: _____

Physician: _____ Office Location: _____ Phone: _____

Conditions: _____

Brief Description of Condition(s) and Date of Diagnosis: _____

_____

When was the last time your scholar was seen by a physician for this condition(s)? _____

How many times has this scholar been seen in the emergency room in the past year for this condition(s)? _____

How many times has this scholar been hospitalized in the past year from this condition(s)? _____

How many days would you estimate that this scholar missed from school or daycare last year for this condition(s)? _____

Please list medications taken at home: _____

Please list medications to be taken at school (**No IV medications will be given by school personnel**): _____

_____

Equipment needed (***to be supplied by Parent***): _____

Restrictions (***If your child may not participate in physical education activities, or may need assistive devices, a doctor's note is required***): _____

_____

Field Trip Plan: _____

Does your child participate in any school sponsored programs, either before school or after school? If yes, please list: _____

_____

Please add any additional information you feel is needed to safely care for your child: _____

_____

Authorization for Healthcare Provider and School Nurse to Share Information:

I authorize my scholar's school nurse to assess my child in regards to his/her special health care needs and to discuss these needs with my scholar's physician as needed throughout the school year. I understand this is for the purpose of generating a healthcare plan for my scholar. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/Guardian Signature: _____ Date: _____

Signature below indicates that the plan has been reviewed and appropriate documentation is complete.

School Nurse Signature: _____ Date: _____

Revised 2/2025