HEALTH INFORMATION

TO BE COMPLETED BY PARENT/GUARDIAN EACH SCHOOL

مدينة العلوم
Madinatul Uloom
THE CITY OF KNOWLEDGE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PART 1: PARENT OR GUARDIAN TO COMPLETE.

Name ***(Last, First, M.I.):***		Gender ☐ M ☐ F
DOB:	Grade:	School Year:
Home Phone: ( )	Father's Work Phone: ( )	Mother's Work Phone: ( )

My child has a medical condition that may affect his or her school day: ☐ NO ☐ YES (please complete Part 2)

_____

Parent's or Guardian's Name

_____

Parent's or Guardian's Signature Date

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/guardian is responsible for providing the school with any medication, special food, or equipment that the student will require during the school day.

☐ **ALLERGIES**

Allergy Type:

☐ Food List food(s) _____

☐ Bee sting

☐ Other (list) _____

Reactions:

☐ Coughing	☐ Hives	☐ Rash
☐ Difficulty breathing	☐ Local swelling	☐ Wheezing
☐ Generalized swelling	☐ Nausea	☐ Other

Currently prescribed treatments to be used *IN SCHOOL:*

☐ Oral antihistamine (Benadryl, etc.)	☐ Epi-Pen	☐ Other

☐ **ASTHMA**

Triggers: ☐ Exercise	☐ Environmental	☐ Other (list)
Physical Education Restrictions: ☐ None	☐ Self-limits	☐ Other

Symptoms or reactions:

☐ Chest tightness, discomfort, or pain	☐ Difficulty breathing	☐ Throat itch, tightness, or soreness
☐ Coughing	☐ Hoarseness	☐ Wheezing

☐ Other _____

Currently prescribed treatments to be used *IN SCHOOL:*

☐ Inhalers	☐ Oral antihistamines	☐ Oral steroids
☐ Nebulizer	☐ Oral bronchodilator	☐ Peak flow monitoring

Date of last hospitalization related to asthma _____

☐ **DIABETES**

Currently prescribed treatments to be used *IN SCHOOL:*

☐ Insulin: ☐ Syringe ☐ Pen ☐ Pump

☐ Blood sugar testing

☐ Glucagon

☐ Oral medication(s) List medication(s)_____

Is special scheduling of lunch or Physical Education required? ☐ NO ☐ YES

CONTINUE ON REVERSE

☐ **SEIZURE DISORDER**		
Type of seizure:		
☐ Absence (staring, unresponsive)	☐ Complex Partial	☐ Generalized Tonic-Colonic (Grand Mal/Convulsive)
Other (explain) _____		
Physical Education Restrictions: ☐ NO ☐ YES		
Medication needed *IN SCHOOL:* ☐ NO ☐ YES	List medication(s) _____	
Date of last seizure _____	Length of seizure _____	

☐ **OTHER HEALTH CONDITIONS**				
☐ Cancer	☐ Hemophilia	☐ Heart Condition	☐ Physical disability	☐ Other (explain) _____
Physical Education Restrictions: ☐ NO ☐ YES				
Medication needed *IN SCHOOL:* ☐ NO ☐ YES List medication(s) _____				
Special procedures (i.e.: catheterization, cardiac monitor, etc.) required *IN SCHOOL:* ☐ NO ☐ YES (explain):_____ _____				

☐ **VISION CONDITIONS**	☐ **HEARING CONDITIONS**
☐ Contacts/glasses	☐ Hearing aid(s)
☐ Other _____	☐ Other _____