Soaring Heights Charter School

Name: _____ DOB: _____

Date: _____ Grade: _____

Dear Parent/Guardian,

To better serve you and your child, please complete and return the following questionnaire about the health history of your child.

Please **check off** any of the following that apply and **explain below**. **Give the year** the health problem was diagnosed and any medication used at this time. Also, address any other existing health problems **not** mentioned on this list.

Disease Hx	Year		Year		Year	Operations Or Injuries	Year
Food Allergies		Diabetes		Otitis Media			
Non-Food/Non Drugs Allergies		Autism Spectrum Disorder		Neuromuscular Disorder			
Asthma		Drug Allergies		Strep Infection			
Congenital Disorder		Heart Disease		ADD/ADHD		Fractures	
Convulsive Disorder		Hepatitis		Influenza			

Other Health Problems:

_____

_____

_____

_____

During the pregnancy, did the mother have any health problem? Yes____ No____
If yes, please explain.

_____

_____

Were there any problems during delivery for the mother or the child? Yes___ No____
If yes, explain.

_____

_____

What was the child's birth weight? _____

After the birth, did the child have any health problems?
Yes_____ No_____ If **yes, please explain.**

_____
_____
_____
_____

Has your child ever been hospitalized? Yes_____ No_____ If yes, please **explain when, why and for how long.**

_____
_____
_____
_____

Has your child ever has surgery? Yes_____ No_____ If yes, **please explain** when and why.

_____
_____
_____
_____

Is your child on any **medications?** Yes_____ No_____ if yes, **please list** the name of the medication and what it is used for.

_____
_____
_____
_____

Does your child have any restriction on physical activity during gym? Yes___ No____
If yes, **please explain** the restrictions and the reason for them.

_____
_____
_____
_____

Thank you for your cooperation.

Sincerely,
Myra Ibarra, School Nurse