

2019-2020 BRDHD Health Questionnaire

Child's Name _____ DOB _____

Primary Medical Provider: _____ Phone: _____

Medications, Vitamins, Herbs, Supplements, Oils taking at home: _____

Please check if the child has a **doctor-confirmed** medical history of any of the issues below.

- | | | |
|--|--|---|
| <input type="checkbox"/> ADHD/ ADD | <input type="checkbox"/> Autism | <input type="checkbox"/> Mood Problems/ Depression |
| <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Immune Deficiency |
| <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Heart Murmur/ Defect | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Life Pack/ LVAD Heart Pump |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Recurrent Urinary Tract Infections |
| <input type="checkbox"/> Urinary Frequency | <input type="checkbox"/> Incontinence of Urine | <input type="checkbox"/> Inability to Void without Catheterization |
| <input type="checkbox"/> Ostomy in Place | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Frequent Stomachaches |
| <input type="checkbox"/> Incontinence of Stool | <input type="checkbox"/> Wears Diapers | <input type="checkbox"/> Constipation requiring MD visits |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Postural Orthostatic Tachycardia Syndrome (POTS) |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Concussion in the past 3 years |
| <input type="checkbox"/> Debilitating Menstrual Cramps | <input type="checkbox"/> Eczema | <input type="checkbox"/> Inability to tolerate extreme heat |
| <input type="checkbox"/> Hearing Loss or Difficulty | <input type="checkbox"/> Vision Loss or Difficulty | <input type="checkbox"/> Dental Decay/ Problems |
| <input type="checkbox"/> Frequent Sinus Infections | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Lactose Intolerant | | <input type="checkbox"/> Inability to Eat without Tube Feeding |
| <input type="checkbox"/> Other _____ | | |

Asthma

Check the things that may bring on this child's asthma? Pollens Dust Animals Exercise Foods
 Illness Heat Weather Changes Scents Smoke Candles Perfumes Seasonal Changes
Other _____

Check the Asthma SYMPTOMS for this child: Coughing Shortness of Breath Wheezing
Please list any other symptoms specific for this child: _____

Doctor-confirmed Allergic Reaction to: (be specific)

Stinging Insects Red Dye Latex Animals
 Food(s): _____
 Medication(s): _____

Check the allergic reaction SYMPTOMS for this child:

Itching/Swelling of Lips, Mouth, Tongue, Throat Hives/Rash Nausea/Vomiting/Stomach Cramps
 Shortness of Breath Wheezing Coughing Dizziness Unconsciousness
Other _____

Medications Needed for School:: Benadryl EpiPen Jr. Epi Pen Twinject Auvi-Q Inhaler Nebulizer
 Glucagon Insulin syringe/ vial Insulin Pen Insulin Pump Diastat Vagal Nerve Stimulator/ Magnet
Other _____

Procedures Needed for School: Catherization Tube Feeding Seizure Monitoring Diabetic Care Ostomy Care
 Respiratory Monitoring Dressing Changes Toileting Monitoring
Other _____

Does your child (per md) require medications for sports, afterschool programs, and/ or field trips? SEE NURSE!

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