

ANNUAL STUDENT HEALTH QUESTIONNAIRE
Massabesic Middle School / Massabesic High School

Student _____ D.O.B _____ Grade _____

IF YOUR CHILD HAS A SENSITIVE HEALTH ISSUE OR HEALTH NEED THAT MUST BE MANAGED AT SCHOOL

MMS: PLEASE CALL 247-6121, EXT. 4005 TO SPEAK DIRECTLY TO THE NURSE

MHS: PLEASE CALL 247-3141, EXT. 2215 TO SPEAK DIRECTLY TO THE NURSE

My child has the following health problems or concerns:

Allergy: Food: _____ Medication: _____
 Insect/Bee _____ Seasonal _____

My child has an **Epipen** prescribed: **Yes / No** Permission to self-carry: **Yes / No**

Asthma: Medications prescribed _____

My son/daughter requires an inhaler at school (please circle): **Yes / No**

My son/daughter has permission to self-carry an inhaler at school: **Yes / No**

Diabetes: **Type 1** **Type 2**

ADHD/ADD **Seizure Disorder** **Depression** **Anxiety**

Bleeding Disorder/concern (please explain) _____

Heart condition (please specify) _____

Eye / Vision Problems (circle all that apply) Wears Glasses / Contacts: **Yes / No**

My student should wear their glasses / contacts: **All the time / For Distance / For Near-sighted activities**

Deafness / Hearing Difficulties: Please Explain (i.e. Assistive devices) _____

History of concussion / brain injury (Dates of injury) _____

Other: Please list any illness, injury or surgery which might affect participation in PE/sports, or other health concerns that the school should be aware of:

MEDICATIONS: Please list the name, dose, frequency, and reason for all medications.

	Medication Name	Strength/ Dose	Time taken	Reason
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

ACETAMINOPHEN / IBUPROFEN ADMINISTRATION AT SCHOOL: (please check the appropriate boxes)*

- I give permission to the School Nurse to administer acetaminophen (i.e. Tylenol), based on my students age/weight, as ordered by the School Physician as needed for pain/fever >101 degrees F.
- I give permission for the School Nurse to administer ibuprofen (i.e. Advil), based on students age/weight, as ordered by the School Physician for pain/fever > 101 degrees F.

**The nurse will assess the student before administration is provided. The School Nurse may contact you if symptoms of concern are identified and further action is recommended. You may be asked to provide these medications AND provide a physician's order if they are required more than 3 times per semester.*

I understand that the information on this form is confidential and will be shared with school staff on a need to know basis if it may impact their health and academic success within RSU 57.

Signature of Parent/Guardian _____ Date _____