Where learning comes to life
CEDAR RAPIDS Community Schools

HEALTH INFORMATION QUESTIONNAIRE
(This information will be shared with school personnel with a Need to know in order to benefit the student)

Student's Name_____ **Date of Birth**_____

School _____ **Grade** _____

Information provided by_____ **Relationship to Student**_____

Parent/Guardian's Legal Name_____ **Phone**_____

Physician_____ **Last exam/care**_____

Health Insurance ____**Yes** _____**No** **Company**_____

Dentist_____ **Last exam**_____

Dental Insurance ____**Yes** _____**No** **Company**_____

Please check those that apply:

_____ **Activity Restrictions**
Describe_____

_____

_____**Medications <u>at home</u> (oral, inhalers, injections)**
Describe_____

_____

_____**Medications at school**
Describe_____

_____

_____**Need assistance in finding healthcare provider or other health resources.**

_____**Request information about Hawk-I (state children's health insurance program)**

_____**Would like to talk with the school nurse about a health concern.**

1/05

Has this child had any of these chronic health conditions?

YES	NO	COMMENTS
____	____	**ADD/ADHD**_____
____	____	**Allergies/Specify:** **To foods**____ **What Reaction?**_____ **To medication**_____ **What Reaction?**_____ **To environment**____ **What Reaction?**_____ **Epipen? ____Yes ____No**
____	____	**Asthma**_____
____	____	**Cancer**_____
____	____	**Emotional/behavioral concerns**_____
____	____	**Diabetes**_____**Glucagon? ____Yes ____No**
____	____	**Headaches**_____
____	____	**Hearing/ear infections**_____
____	____	**Heart problems**_____
____	____	**Muscle or bone problems**_____
____	____	**Seizures**_____
____	____	**Speech Problems**_____
____	____	**Urinary/bowel concerns**_____
____	____	**Vision Problems/Glasses**_____
____	____	**Other**_____

Questionnaire completed by:_____

Date_____

1/05