Gilpin Health Questionnaire

CHILD'S NAME: ____________________ **Birth Date**: _____________ **School Year**: _______________

Does your child have problems with: (please check below) **Grade**: ____________________

	YES	NO	MEDICATION (Name and dose)	NEEDS HELP AT SCHOOL	COMMENTS OR DESCRIBE
Asthma/Respiratory?					
Allergies? To What?					Type of reaction Date of last reaction:
Diabetes?				:	
Seizures/Head Injury/Migraines					Type & date of last seizure
Eating disorders/special diet?					
Heart or blood?					
Skin/Muscles/Bones?					
Bladder/Kidney?					
Stomach/Intestines?					
Moving or coordination?					
Hearing?				Wear Hearing aids? Needs Preferential seating?	
Vision?				Wear Glasses/Contacts?	
Developmental? (Walking, talking)?					
Emotional/Behavioral?					
Does your child take any other medications? Please list.					
Other					

Does your child have treatments or therapies not listed above (Speech, OT, PT, etc.)?

Activity restrictions in school?

Has your child been in the hospital or very sick or hurt in the last year? Explain:

______________________________ ______________________________

Health Care Provider(s) Name **Phone #**

______________________________ ______________________________ ______________________________

Parent /Guardian Signature **Phone # Home / Work** **Date completed**

Thank you! Wendy Moore, RN, Health Office

Connie Oliver Health Office Assistant

Please contact the health office if you would like to discuss any of the information that you feel is confidential at 303-582-3444