BYRAM SCHOOL DISTRICT
ELEMENTARY STUDENT HEALTH SURVEY

Name: _____Birthdate: _____
Primary Language spoken at home _____Other Languages _____
Grade: _____Sex: _____ Name of Local Doctor: _____

Has your child ever had or has now? (Please check at right of each item)

	Yes	No	Year		Yes	No	Year
High blood pressure				Excessive worry or anxiety			
Heart condition				Depression			
Asthma				Ulcer			
Sever Allergies				Severe or chronic abdominal pain			
Contact with tuberculosis				Excessive colds			
Positive tuberculin test				Speech Problem			
Tumor, growth or cancer				Eye trouble			
Diabetes or sugar in urine				Wears glasses			
Serious skin disease				Frequent ear infections			
Concussion				Hearing loss			
Frequent or severe headache				Frequent or painful urination			
Dizziness or fainting spells				Intestinal trouble			
Severe head injury				Wets or soils pants			
Epilepsy (convulsions)				Scoliosis in family			

Has your child had any orthopedic (bone or joint) problems? What? When? Explain:
_____

Has your child had any operations? What? When? Explain: _____

Has your child ever had serious illnesses or injuries other than those already noted? What? When? Explain: _____

_____

Has your child been diagnosed with Attention Deficit Disorder? Explain: _____

_____

List any medications your child is allergic to: _____

_____

Does your child have severe bee sting sensitivity? Local_____ or General_____Explain:_____

_____

Does your child have other health or behavior problems (learning, hyperactivity tantrums, coordination)?_____

_____

Is your child under regular medical supervision for any of the above conditions? If yes, give name of physician: _____

Do you have any special question or concerns about your child's health?_____

_____

If so, please contact the school nurse for a confidential conference.