

Montessori Regional Charter School
Health Questionnaire
2011-2012

Student Name _____ Grade _____

Health History – Please use back of sheet if needed

Please *circle* all that apply:

ADD/ADHD

Allergies: ***see note below** Specify _____

Arthritis/Rheumatic Disease

Asthma **** see note below**

Bleeding Disorder/Anemia

Cardiovascular Condition

Cardiovascular Condition

Cerebral Palsy

Cystic Fibrosis

Diabetes

Type I _____ Type II _____

Eating Disorder

Epilepsy/Seizure Disorder

Genitourinary Disorder

Immunosuppressive Disorder

Sickle Cell Disease

Spina Bifida

Tourette's Syndrome

If your child has a bee sting allergy, a written note from your physician and the medication must be sent to school medical office. *Please do not send in to school with your child, a parent or guardian must bring the medication to the office.

****If your child uses an inhaler, a written note from your physician and the medication must be sent to school to school medical office. *Please do not send in to school with your child, a parent or guardian must bring the medication to the office.***

Other – Please be specific

Is your child currently under treatment for any medical condition?

YES _____ NO _____

Please describe:

Signature of Parent or Guardian

Date