

**CIRCLE OF SEASONS CHARTER SCHOOL HEALTH QUESTIONNAIRE
2025-2026**

The information requested on this form will be of assistance to the certified school nurse in evaluating the health status of your child and assisting him/her to receive maximum benefits from this educational opportunity. Please complete all sections. This form will be kept in the nurse's office.

Student's Name _____ Birthdate _____ M F

Student's Address _____

Parent(s) Name(s) _____ Home Phone _____

Cell Phone _____ Work Phone _____

Parent(s) Name(s) _____ Home Phone _____

Cell Phone _____ Work Phone _____

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____

Emergency Contact Information (to whom child may be released if parent/guardian is unavailable)

Name _____ Relationship _____

Cell/Home Phone _____ Work Phone _____

Name _____ Relationship _____

Cell/Home Phone _____ Work Phone _____

MEDICAL INFORMATION

Preferred hospital is _____

Student's Primary Care Physician _____ Phone _____

Student's Dentist _____ Phone _____

Is the student currently being seen by a specialist for a health concern? ☐ Yes ☐ No If yes, provide name of specialist, phone number and reason he/she sees this doctor.

List any hospitalizations and/or surgeries

Date	Description – why hospitalized/type of surgery

List Allergies

Allergy	Treatment (if any)

Has the student been prescribed an Epi-Pen? ☐ Yes ☐ No If yes, please contact school nurse.
 For what reason was it prescribed? _____

List all current medications including those prescribed by a health care provider or purchased over the counter.

Medication Name	Dosage	How Often Taken	Reason medication is taken

Health History

Check any of the following illnesses/conditions your child has experienced or been treated for. Indicate approximate date.

	Check		Check		Check
Anxiety		Diphtheria		Mumps	
Arthritis		Ear Infections		Nosebleeds	
Asthma		Eczema		Pneumonia	
Autism Spectrum Disorder		Headaches/Migraines		Polio	
Bladder Infection		Heart Murmur		Rheumatic Fever	
Blood Disorder		Heart Problems		Rubella (German Measles)	
Blood Pressure-High or Low		Hepatitis		Scarlet Fever	
Broken Bones		High Fever		Seizures	
Bronchitis		Hives		Stomach Aches	
Cancer		Kidney Disease		Thyroid Disease	
Celiac Disease		Malaria		Tonsillitis	
Chickenpox		Measles		Tuberculosis	
Concussion		Meningitis		Typhoid	
Diabetes		Mental Health Issues		Whooping Cough	
Depression		Mononucleosis		Other	

Additional Comments _____

Parent/Guardian Consent and Agreement For Emergencies

As parent/guardian, I consent to have my child receive basic first aid by school staff and, if necessary, be transported to receive emergency medical care. I will be responsible for all charges not covered by insurance.

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____