

**Pomfret Community School**

**Annual Health Questionnaire**

DATE: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

1. If your child has any medical conditions we should know about, please list below.

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2. Please list below any illness, injury or surgery your child had during the last year.

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3. Does your child have any of the following conditions? If yes, please specify.

Allergies                    \_\_\_ no            \_\_\_ yes \_\_\_\_\_

Bee sting reaction        \_\_\_ no            \_\_\_ yes \_\_\_\_\_

Asthma Condition        \_\_\_ no            \_\_\_ yes \_\_\_\_\_

4. List any medication your child takes routinely.

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5. List any medication your child takes on an emergency basis.

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6. List any communicable disease your child had during the past year.

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7. Does your child have Health Insurance?            Yes \_\_\_            No \_\_\_

8. Does your child wear glasses?                      Yes \_\_\_            No \_\_\_

9. May I share this information with appropriate school staff?    Yes \_\_\_            No \_\_\_

Parent Signature \_\_\_\_\_

( Please return this form to the school nurse )

