

ABINGTON SCHOOL DISTRICT
SCHOOL HEALTH SERVICE

SPECIAL HEALTH PROBLEMS SURVEY

Name _____

Grade _____ Date _____

School Building _____

To the Parent or Guardian:

Your child's health record indicates that he/she has been under care for the following medical problem(s): _____

If appropriate, give the date of last episode: _____

It is important that the school nurse have a record of the current health status of the student. Please fill in the following information and return to the school nurse so that the student's health record may be updated.

School Nurse

1. Does the above medical problem(s) still exist? _____
2. Please list any other medical problems: _____

3. Does he/she take medication regularly?
If yes, please give the name of the medicine _____.
How much is taken? _____
Times taken _____
4. Is it necessary that prescription or over-the-counter medication be taken during school hours? _____
If yes, written parental authorization and physician's instructions are both required.
Medication must be in its original container.
5. Does he/she regularly receive treatment/therapy or undergo any testing procedures?
If yes, please indicate kind and how often taken: _____
6. Doctor, clinic, or medical center that cares for student:
Name: _____
Address: _____
Phone: _____
7. Special instructions concerning classroom activities:

Special seating required? _____
8. Special instructions concerning physical education:

Special program? _____. If a special program or is necessary, a doctor's note is required.

Your prompt response is appreciated. By affixing your signature to this survey, you are giving consent that Abington School District Health Services can share this information with school staff for the well being of your child.

Date

Parent/Guardian