MAQUOKETA VALLEY
Community School District

2023-2024 YEARLY HEALTH FORM

Please complete the form and return it to the school office.

Students Name: _____

Student's DOB: _____ Grade: _____

Allergies (check all that apply)
___ Medicine
___ Environmental
___ Latex
___ Food
___ Insects (please specify)
___ Other (please specify)

Specify what happens when exposed to the allergen (ex: rash).

_____

Does your child? (circle the correct response: Y = yes, N = no)

Need a special diet? Y / N
If yes, the school requires a prescription from your doctor.

Have asthma? Y / N
If yes, please list what may trigger their asthma. _____

Do they currently take medication? Y / N
If yes, please list the name of the medication(s). _____

Any other frequent respiratory conditions? Y / N
If yes, please specify. _____

Have Attention-Deficit/Hyperactivity Disorder? Y / N (ADD / ADHD)

Do they currently take medication? Y / N
If yes, please list the name of the medication(s). _____

Have a blood disorder? Y / N
If yes, please specify. _____

Have blood pressure issues? Y / N (High / Low)

History of cancer? Y / N
If yes, please specify. _____

Have Cystic Fibrosis? Y / N

Have diabetes? Y / N (Type 1 / Type 2)

Pump: _____ Insulin (pen / injection): _____

Other medication: _____

Have a digestive disorder (IBS, Crohns)? Y / N

If yes, please specify. _____

Had a serious head injury? Y / N

If yes, please specify. _____

Have a hearing disorder? Y / N

If yes, do they use hearing aids? Y / N

Have a heart condition? Y / N

If yes, please specify. _____

Have a kidney or bladder problem? Y / N

If yes, please specify. _____

Been diagnosed with migraine headaches? Y / N

Been diagnosed with any mental health issues? Y / N

If yes, please specify. _____

Do they currently take medication? Y / N

If yes, please list the name of the medication(s). _____

Have any muscle, bone, or mobility problems? Y / N

If yes, please specify. _____

Had any surgery since last year? Y / N

If yes, please specify. _____

Have any vision issues? Y / N

If yes, please specify. _____

Have any other medical condition(s) not listed? Y / N

If yes, please specify. _____

_____ _____

Parent Signature Date