

Great Neck School



165 Great Neck Road
Waterford, CT 06385

Pat Fedor, Principal
860-442-2593

ANNUAL HEALTH QUESTIONNAIRE

*Information provided will be shared with appropriate staff as stated in the
Family Education Rights & Privacy Act (FERPA).*

Student: _____ **Grade:** _____

Physician, Dentist & Specialist: _____

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

- | | | |
|-----|----|--|
| Yes | No | Allergies (food, medication, other) _____ |
| Yes | No | Bee sting reaction |
| Yes | No | Asthma condition |
| Yes | No | Orthodontic braces or appliances |
| Yes | No | Vision/eye problem |
| Yes | No | Wears glasses/contacts (for reading, distance or full-time wear) |
| Yes | No | Hearing/ear problem |
| Yes | No | Diabetes |
| Yes | No | Seizures |
| Yes | No | Heart condition |
| Yes | No | Urinary condition |
| Yes | No | Skin disorder |
| Yes | No | Speech problems |
| Yes | No | Scoliosis |

Please list dates of any illness, injury or surgery your child has had during the last year.

List dates of all immunizations your child has had within the past year.

List all medications your child takes routinely, including dosage and time.
(Medication cannot be administered at school without a doctor's order.)

List all medications your child takes on an emergency basis and include the reason.

Additional comments:

Signature Parent/Guardian:

Daytime Phone: