ST. JOHNS COUNTY SCHOOL DISTRICT

HEALTH SERVICES MEDICAL QUESTIONNAIRE FOR PARENT/GUARDIAN

SCHOOL YEAR:_____

Student's Name: _____ Date of Birth: _____

Dear Parent/Guardian:

School records indicate your child has the following medical condition: _____

_____

Please provide the following information:

How long has your child had this illness?	
When was your child last seen for this condition?	
Does your child currently take medication for this condition at home or school? If yes, please explain:	

Are there any physical activities your child should not participate in? ☐ Yes ☐ No
If yes, please explain: _____

_____

*Please note: If your child is not to participate in physical education classes, a physician's note is required.

Physician's Name _____ Phone: _____
Physician's Address _____ Fax: _____
_____

Please add any additional information needed to safely care for your child: _____

_____

_____

_____

_____

IF YOUR CHILD IS NO LONGER BEING TREATED FOR THIS CONDITION AND YOU WOULD LIKE IT REMOVED FROM THE SCHOOL RECORDS, PLEASE SIGN BELOW AND RETURN TO THE SCHOOL NURSE.

_____ _____ _____
Parent/Guardian Signature **Printed Name of Parent/Guardian** **Date**