

**Temple Beth Sholom Hebrew School
2009-2010 Health Questionnaire
THIS FORM TO BE SIGNED AND RETURNED FOR EACH STUDENT**

In an effort to provide the best and safest environment for your child, please complete the following questionnaire. This will allow us to meet individual needs and to have important information on hand in case of an emergency. All information will be kept in strictest confidence.

Student's name _____ **Grade** _____

Parent signature _____ **Phone number** _____

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|---|-----|----|
| 1. Does your child have any food allergies?
If yes, please identify _____ | Yes | No |
| 2. Does your child have any dietary restrictions?
If yes, please identify _____ | Yes | No |
| 3. Has your child ever had a severe allergic reaction to bug bites or bee stings? | Yes | No |
| 4. Does your child have any fears or phobias the school should know about? _____ | Yes | No |
| 5. Does your child have asthma?
If so, please identify the type _____ | Yes | No |
| 6. Does your child have any medical conditions not mentioned above? If so, please identify
_____ | Yes | No |
| 7. Does your child take any medication on a regular basis?
If so, please identify all medications, as this may be useful in an emergency situation.
_____ | Yes | No |
| 8. Does your child have any medication allergies?
If so, please identify all medication allergies, as this may be useful in an emergency situation.
_____ | Yes | No |
| 9. Does your child have any visual / hearing issues we should know about (apart from wearing glasses)? If so, please identify. _____ | | |

Please feel free to add any additional information that you feel the school should have regarding your child's health. _____

