Temple Beth Sholom Hebrew School
2011-2012 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**______________

1. Does you child have any food allergies? Yes No
   If yes, please identify______________________

2. Does your child have any dietary restrictions? Yes No
   If yes, please identify______________________

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? Yes No
   If so, please identify the type _______________

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? Yes No
   If so, please identify all medications, as this may be useful in an emergency situation.
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8. Does your child have any medication allergies? Yes No
   If so, please identify all medication allergies, as this may be useful in an emergency situation.
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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. ____