URBANA SCHOOL DISTRICT #116
205 N. Race Street; P. O. Box 3039
Urbana, Illinois 61803-3039

HEALTH SURVEY

Child's Name_____ Date_____

School_____ Grade_____

Your child's health and well-being are essential to the learning process. Some special services are available which may help your child. The information requested will assist us in planning for your child's specific needs.

		circle one	
1.	Was your child born prematurely?	yes	no
2.	Did your child have oxygen loss at birth?	yes	no
3.	Has your child had a serious head injury?	yes	no
4.	Has your child had:		
	CMV (cytomegalovirus)	yes	no
	Hepatitis, if yes, what type_____	yes	no
	Meningitis	yes	no
	Rheumatic fever	yes	no
	Tuberculosis or contact with TB	yes	no
5.	Has your child been treated for:		
	ADD/Hyperactivity	yes	no
	Asthma	yes	no
	Allergies: Please List:	yes	no
	food_____	yes	no
	insects_____	yes	no
	other_____	yes	no
	Diabetes	yes	no
	Ear infections	yes	no
	Has child had tubes?	yes	no
	Does child now have tubes?	yes	no
	Does child have a hearing loss?	yes	no
	Does child have frequent nosebleeds?	yes	no
	Heart condition, if yes, what type_____	yes	no
	Seizures, if yes, what type_____	yes	no
	Speech difficulty	yes	no
	Does your child wear glasses?	yes	no
	Does child have amblyopia (lazy eye)?	yes	no

(complete both sides)

6. Has your child been hospitalized and or had surgery? yes no

Hospitalization for: Date:

Surgery for: Date:

7. Does your child have physical limitations or disabilities: yes no
Please explain

8. Does your child have any restrictions of activity? yes no
Please explain

9. Is your child on medication? yes no
Please list

10. List any special concerns you have about your child's health.

Thanks for your help.

4/00