2019-2020 BRDHD Health Questionnaire

Child's Name _____ DOB _____

Primary Medical Provider: _____ Phone: _____

Medications, Vitamins, Herbs, Supplements, Oils taking at home: _____

_____

Please check if the child has a **doctor-confirmed** medical history of any of the issues below.

____ ADHD/ ADD
____ Developmental Delays
____ Spina Bifida
____ Genetic Disorder
____ Heart Murmur/ Defect
____ High Blood Pressure
____ Urinary Frequency
____ Ostomy in Place
____ Incontinence of Stool
____Migraine Headaches
____Seizures
____ Debilitating Menstrual Cramps
____Hearing Loss or Difficulty
____ Frequent Sinus Infections
____Lactose Intolerant
____ Autism
____Cerebral Palsy
____ Cystic Fibrosis
____ Hemophilia
____ Pacemaker
____Kidney Disease
____ Incontinence of Urine
____ Acid Reflux
____ Wears Diapers
____Neurological Problems
____ Head Injury
____Eczema
____Vision Loss or Difficulty
____Frequent Ear Infections
____ Mood Problems/ Depression
____ Down Syndrome
____ Immune Deficiency
____ Sickle Cell Anemia
____Life Pack/ LVAD Heart Pump
____ Recurrent Urinary Tract Infections
____ Inability to Void without Catheterization
____ Frequent Stomachaches
____Constipation requiring MD visits
____ Postural Orthostatic Tachycardia Syndrome (POTS)
____ Concussion in the past 3 years
_____Inability to tolerate extreme heat
____Dental Decay/ Problems
____Diabetes
____Inability to Eat without Tube Feeding
____ Other _____

____Asthma

Check the things that may bring on this child's asthma? ___ Pollens ____ Dust ____ Animals ____ Exercise ____ Foods
____ Illness ____Heat ____Weather Changes ____Scents ____Smoke ____Candles ____Perfumes ___Seasonal Changes
Other_____

Check the Asthma SYMPTOMS for this child: ____Coughing ____Shortness of Breath ____Wheezing
Please list any other symptoms specific for this child: _____

____**Doctor-**confirmed Allergic Reaction to: (be specific)

_____Stinging Insects ____ Red Dye ____Latex ____Animals
_____Food(s): _____
_____Medication(s):_____

Check the allergic reaction SYMPTOMS for this child:
_____Itching/Swelling of Lips, Mouth, Tongue, Throat _____Hives/Rash _____Nausea/Vomiting/Stomach Cramps
_____Shortness of Breath _____Wheezing _____Coughing _____Dizziness _____Unconsciousness
Other _____

Medications Needed for School:**:** ___Benadryl ___EpiPen Jr. __ Epi Pen __ Twinject ___ Auvi-Q ___Inhaler ___Nebulizer
___Glucagon ____Insulin syringe/ vial ____Insulin Pen _____Insulin Pump ____Diastat ___Vagal Nerve Stimulator/ Magnet
Other _____

Procedures Needed for School: ____ Catherization ____ Tube Feeding _____ Seizure Monitoring ____ Diabetic Care ____Ostomy Care
____ Respiratory Monitoring ____Dressing Changes _____ Toileting Monitoring
Other _____

Does your child (per md) require medications for sports, afterschool programs, and/ or field trips? SEE NURSE!

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