YBH of Passaic - 270 Passaic Avenue, Passaic, NJ 07055 - 973-777-0735 Fax: 973-777-9477

HEALTH INFORMATION QUESTIONNAIRE

One form per family required

Family's Last Name: _____

Mother's First Name: _____ Last Name: _____

Father's First Name: _____ Last Name: _____

Student(s) at YBH:

First Name	Last Name	Date of Birth	Grade

(Parent must complete the following questions 1 – 4)

1. Does student have a food allergy? (circle one) YES NO

If yes, write child's first name _____ _____

Allergic to _____ _____

If student requires EpiPen or Benadryl in school for food allergy, have physician complete "Allergy Action Plan."

2. Does student have asthma? (circle one) YES NO

If yes, write child's first name _____ _____

If student requires asthma medication in school, have physician complete "Asthma Treatment Plan."

3. Does student have a medical condition? (circle one) YES NO

(Ex. diabetes, seizure disorder, hearing loss, hearing aid, seasonal allergy, etc.)

If yes, write child's first name _____ _____

Medical Condition _____ _____

4. Does student take any medication? (circle one) YES NO

If yes, write child's first name _____ _____

Medication _____ _____

If student requires medication in school, have physician complete "Authorization to Administer Medication in School" form.

PEDIATRICIAN NAME _____ Tel. No. _____

MEDICAL SPECIALIST (Allergist, Pulmonologist, etc.)

_____ Tel. No. _____

DENTIST NAME _____ Tel. No. _____

EYE DOCTOR NAME _____ Tel. No. _____