BEECHER ROAD SCHOOL HEALTH QUESTIONNAIRE

Please read all questions carefully and answer with a yes or no to the best of your ability. Please explain in detail where needed. Please print. Thank you.

PUPIL'S NAME_____ BIRTHDATE_____

PUPIL'S ADDRESS_____ GRADE_____ AGE_____

_____

I. FAMILY STATUS

Mother's Name_____ Address_____

Mother's Telephone Number-Home_____ Work_____

Father's Name_____ Address_____

Father's Telephone Number-Home_____ Work_____

Single_____ Married_____ Divorced_____ Separated_____ Widowed_____

Child's Physician: Name_____

Address_____

Telephone_____

II. ALLERGIES

1. Does your child have KNOWN allergies of any kind?_____

   If yes, please state the allergy and the reaction:_____

   _____

   Does your child need immediate medication for this condition?_____

   If yes, please indicate what medication the doctor has ordered:_____

   _____

IF THE ABOVE ANSWER IS YES YOU WILL NEED A MEDICATION PERMISSION FORM FILLED OUT BY BOTH THE DOCTOR AND PARENT

2. Does your child have asthma?_____

   What usually "brings on" your child's asthma attack?_____

   _____

   Is your child's asthma severe enough to need medication in school?_____

   What medication?_____

IF THE ABOVE ANSWER IS YES YOU WILL NEED A MEDICATION PERMISSION FORM FILLED OUT BY BOTH THE DOCTOR AND PARENT

Does your child have any physical limitations due to his/her asthma?_____

_____

3. Does your child have hayfever (pollen allergies)?_____

4. Does your child have eczema?_____ If so, where?_____

III. **ILLNESS OR OPERATION**

1. Has your child ever had an operation?_____If yes, please state the date, reason and type of surgery.

_____

_____

2. Has your child ever been hospitalized for any other reason?_____If yes, please state why:_____

_____

IV **CONTAGIOUS DISEASES** - Please answer yes or no and date

Chickenpox_____Scarlet Fever_____

Fifth Disease_____Mononucleosis_____

Meningitis_____Hepatitis_____

Strep Throat_____

V **MISCELLANEOUS**

1. Has your child ever had any convulsions or seizures?_____If yes, please explain:_____

_____

2. Has your child ever had a serious or significant accident or injury?_____Please explain and give dates if possible:

_____

_____

3. Does your child have any difficulties with vision?_____Does he/she wear glasses or contacts?_____
4. Does your child have any difficulties with hearing?_____If yes, please explain:_____

_____

5. Does your child have any physical limitations according to your doctor?_____If yes, please explain:

_____

_____

May your doctor be contacted regarding the above so that your child may be accommodated within the school setting and program?_____

6. Is your child on any regular medications?_____If yes, you must obtain a medication permission form from the school nurse if the medication must be given during school hours.

Please name the medication(s):_____

_____

7. Does your child have any history of any problem or condition not covered in this questionnaire that you would like the teacher(s) and/or school nurse to be aware of?_____

_____

_____

_____ _____

SIGNATURE OF PARENT DATE

THANK YOU FOR HELPING US GIVE BETTER HEALTH CARE TO YOUR CHILD.
SINCERELY,
BEECHER ROAD SCHOOL NURSES