BEECHER ROAD SCHOOL HEALTH QUESTIONNAIRE

Please read all of the 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

Student's name:____Birthdate:______________________________

Student's Address:____Grade:___________
Age:________________

____

- **Family Status**

Parent 1 Name:___________________________________Address:____________________________________

Parent 1 Phone #:________________________________ Alternate #:_________________________________

Parent 2 Name:__________________________________ Address:____________________________________

Parent 2 Phone #:________________________________ Alternate #:_________________________________

Child's Physician Name:____

Address:____Phone:_____________________________

II. **Allergies**

- 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 any hay fever (pollen allergies)?____

4. Does your child have eczema?_____________If so, where?
____

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:_________
   ____
   ____

CONTAGIOUS DISEASES - Please answer yes or no and date

Chickenpox:__________________________Scarlet Fever:______________________________
Fifth Disease:_________________________Mononucleosis:______________________________
Meningitis:___________________________Hepatitis:___________________________________
Strep Throat:________________________

MISCELLANEOUS

- Has your child ever had any convulsions or seizures?_______If yes, please explain:____________________

  ____

2. Has your childever had a serious or significant accident or injury?_____Please explain and give dates:_____
   ____
   ____
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 the 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