STUDENT HEALTH QUESTIONNAIRE

Today's Date:					
Previous School Attended:				Child's Grade:	
Child's Name:		DOB: / /		☐ M	☐ F
Child's Home Address:		Home Phone			
Child Lives With :	☐ Both Parents	☐ Mother	☐ Father	☐ Guardian	

PARENT/GUARDIAN'S - EMERGENCY CONTACT INFORMATION

1	Mother's Cell Phone	Mother's Work Phone	Mother's Place of Work
2	Father's Cell Phone	Father's Work Phone	Father's Place of Work
3	Guardian's Cell Phone	Guardian's Work Phone	Guardian's Place of Work

IN CASE OF AN EMERGENCY OR ILLNESS PLEASE *PRINT* THE NAME/S OF ALL THOSE THAT YOU WOULD TRUST TO PICK-UP YOUR CHILD AT SCHOOL IN YOUR ABSENCE

	Name of Trusted Adult	Their Phone Number	Their Relationship to Your Child
1			
2			

PLEASE *PRINT* THE NAMES OF THIS CHILD'S BROTHERS/SISTERS THAT CURRENTLY ATTEND WATERBURY SCHOOLS

	Print Name of Sibling	DOB	School They Attend	Living at the Same Address?
1		/ /		☐ Yes ☐ No
2		/ /		☐ Yes ☐ No
3		/ /		☐ Yes ☐ No

STUDENT HEALTH ASSESSMENT RECORD PLEASE CIRCLE "Y" IF "YES" OR "N" IF "NO"

Any Health Concerns	Y	N	Hospitalizations/Emergency Room Visits	Y	N	Concussion	Y	N
Allergies to Food or Bee Stings	Y	N	Any Broken Bones or Dislocations	Y	N	Fainting or Blacking Out	Y	N
Allergies to Medications	Y	N	Any Muscle or Joint Injuries	Y	N	Chest Pain	Y	N
Any Other Allergies	Y	N	Any Neck or Back Injuries	Y	N	Heart Problems	Y	N
Any Daily Medications	Y	N	Problems Running	Y	N	High Blood Pressure	Y	N
Any Problems with Vision	Y	N	"Mono" Mononucleosis in this past year	Y	N	Bleeding More Than Expected	Y	N
Uses Glasses or Contacts	Y	N	Has ONE Kidney or Testicle	Y	N	Problems Breathing or Coughing	Y	N
Hearing Problems	Y	N	Excessive Weight Gain/Loss	Y	N	Smoking	Y	N
Speech Problems	Y	N	Dental: Braces, Caps, Bridges	Y	N	Asthma treatment (Past 3-years)	Y	N
FAMILY HISTORY: Has Any Relative Ever Have a Sudden Unexplained Death (Less Than 50-years old)				Y	N	Seizure Treatment (Past 2-years)	Y	N
Do Any Immediate Family Members Have High Cholesterol				Y	N	Diabetes	Y	N
				Y	N	ADHD/ADD	Y	N

PLEASE EXPLAIN ALL "YES" ANSWERS BELOW - FOR ILLNESSES, INJURIES, ETC., PLEASE LIST THE CHILD'S AGE & YEAR AT THAT TIME

IS THERE ANYTHING THAT YOU WANT TO DISUCSS WITH THE SCHOOL NURSE? EXPLAIN BELOW:

PLEASE LIST ALL MEDICATIONS THAT YOUR CHILD WILL NEED TO TAKE IN SCHOOL:

RELEASE OF INFORMATION STATEMENT: *I give permission for release and exchange of information on this form between the school nurse and the health care provider for confidential use in meeting my child's health and educational needs in school.*

PARENT/GUARDIAN SIGNATURE DATE **H: School Forms/Health Questionnaire 2013**