

**HEALTH QUESTIONNAIRE**Pupil: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name First MI

Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

<b>PHYSICAL HISTORY</b>	<b>YEAR</b>
Accident-Serious	
Allergy* - Drug/Other	
Asthma*	
Blood Disorder	
Cardiac Disease/Problem	
Chicken Pox (date required)	
Congenital Deformity	
Diabetes	
Hearing Loss	
Hypertension	
Illness – Serious	
Scarlet Fever	
Neurological Disorder	
Otitis Media (Ear Infection)	
Rheumatic Fever	
Seizure Disorder (Epilepsy) **	
Surgery** - Serious	
TB Contact	
Urinary Problem	
Vision Loss	
Daily Medication	
<b>INJURIES</b>	
Head**	
Back**	
<b>OTHER</b>	
<b>COMMENT(S):</b>	

**REQUIRED SCREENING**

I understand the following screenings will be provided to my child as required: vision, hearing, scoliosis and Acanthosis Nigricans. The school will follow the required screening schedule.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\* Please indicate an "M" for moderate or an "S" for severe.

\*\* Details needed, please use **COMMENTS** section