2019-2020 Student Health Questionnaire

Student's Name _____ Upcoming Grade _____
Birthdate _____ Sex _____

Mother's Name:_____
Father's Name:_____

Who is the child's regular physician? _____Date of last exam?_____

Birth Health Information:

1. Did the mother have any unusual problems or illness during the pregnancy or delivery?
   _____ Yes _____ No
   If yes, explain briefly:_____
   _____

2. Did this child have any unusual problems or complications during delivery? _____Yes _____No
   If yes, explain briefly: _____
   How much did the child weigh when born: _____
   Was this child born more than 2 weeks late or early?_____

3. Did this child have any sickness or problems while in the hospital? _____ Yes _____ No
   If yes, explain briefly: _____
   _____

Growth and Development Information:

1. Please give the approximate age at which the Child:
   _____ Sat up alone _____ Walked _____ Said single words
   _____ Said sentences _____ Was toilet trained

2. How does this child's development compare to other children, such as brothers, sisters or playmates?
   _____ About the same _____ Slower _____ Faster

Health Conditions: *Please check any this child has had*

_____ Chicken Pox (what year?)
_____ Diabetes
_____ Eye problems, poor vision or crossed eyes
_____ Frequent ear infections
_____ Tubes in ears
_____ Frequent headaches
_____ Frequent nosebleeds
_____ Frequent sore throats
_____ High fevers
_____ Poor hearing
_____ Seizures or epilepsy
_____ Sickle cell disease
_____ Toothaches/dental infection
_____ Concussion/head injury
_____ Brain Tumor
_____ Meningitis/Encephalitis
_____ Other?
List: _____
_____

Allergies and Asthma:

1. Please list and describe allergies or reactions to:
   Medicines/drugs _____

   Foods/plants/others _____

   Bee or wasp stings _____

2. If the allergy is severe, what is the recommended treatment for a reaction? _____
   _____ Allergy shots? _____

3. Does this child have asthma that has been diagnosed by a doctor? _____ Yes _____ No

   If yes, what treatment has been prescribed? _____
   _____

Injuries, Illness & Surgeries:

Please list any severe injuries, illnesses or surgeries:

Injuries, Illnesses, Surgeries	Age of Child	If Hospitalized, Check Here

Additional Information:

1. What medications are given daily? _____

2. What medications are given frequently, but not daily?_____

3. This child is usually: _____very active _____normally active _____rather inactive

4. Do you have any other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware? If yes, please explain:_____
   _____
   _____

5. Does this child have any adaptive or medical needs? ____Yes ____No
   (i.e., glasses, hearing aids, walkers, leg braces, wheelchair, catheter, feeding tube, dietary restrictions, etc.)
   If yes, please describe:_____
   _____
   _____
   _____

Completed by:_____ Date:_____
Relationship to student:_____