TO BE COMPLETED BY PARENT

STUDENT HEALTH QUESTIONNAIRE

Student's Name ______________________________________ Birthdate ___________ Birthplace ___________

Father's Name _______________________________________ Mother's Name _____________________________

Address ____ Phone ________________________

In case of illness or injury, parents/guardians will be contacted first. Please list any work/cell phone numbers where we can contact you. Also list any emergency contacts with phone numbers, in case we are unable to contact you. Parents are the only persons who can legally start medical treatment if needed.

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Family physician's name _______________________________ Address __________________________________

Hospital affiliated with ______________________________________ Phone number ______________________

In the event that any physical activity should be limited, a doctor's written request must be submitted to the Health Office.

Does your child have any physical limitations? Yes ______ No ______ Explain: _______________________

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List any Serious Injuries ____

List any Operations ____

Does your child have a history of any of the following? (Dates and explain on back):

Heart Disease		Seizure Disorder		Ear Conditions	
Diabetes		Anemia		Tubes in Ears	
Allergies		Urinary Tract Infections		Glasses	
Asthma		Frequent Sore Throats		Visual Problems	
Pneumonia		Scarlet Fever		TB in family	

Please add any other information that you feel will be helpful to us: ___________________________________

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Is your child presently on any medication? No ___ Yes ___ Explain ___________________________________

Birth History – Normal Delivery? Yes ___ No ___ Explain ____

Date _______________________ Parent Signature ____

If you need more room to write, please use the back of this sheet.
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