

**MARLBORO CENTRAL SCHOOL DISTRICT**  
**Health Office Information Questionnaire - Please be very specific**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Family Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**I give the school nurse permission to contact my child's physician in case of a medical emergency.**

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

**Has this student had any of the following sicknesses or conditions? If so, please include the dates of each.**

Chickenpox: _____	Diabetes: _____
German Measles: _____	Measles: _____
Scarlet Fever: _____	Rheumatic Fever: _____
TB or Contact: _____	Mumps: _____
High Blood Pressure: _____	Pneumonia: _____
Asthmatic Condition: _____	Allergic Reactions: _____
Whooping Cough: _____	Allergies: _____
Eye/Ear Condition: _____	Phobias: _____
Frequent Colds/Sore Throats: _____	Orthopedic Problems: _____
Frequent Fevers: _____	Epilepsy: _____
Heart Problems: _____	Convulsions: _____
Any Serious Injuries: _____	Any Operations: _____
Hospitalizations: _____	

1. Does the student have any vision problems? \_\_\_\_\_
2. Does the student wear eyeglasses or contact lenses? \_\_\_\_\_
3. Does the student have any type of hearing problems? \_\_\_\_\_
4. Does the student have any speech or language problems? \_\_\_\_\_
5. Does the student have any handicapping conditions? \_\_\_\_\_
6. Does the student have any emotional special needs? \_\_\_\_\_
7. Is the student receiving medical treatment of any kind? \_\_\_\_\_  
If so, please explain: \_\_\_\_\_
8. Is the student receiving any kind of medication and/or herbs? \_\_\_\_\_  
If so, please explain: \_\_\_\_\_
9. Does the student have any physical limitations or restrictions? \_\_\_\_\_  
Please list Doctor to contact: \_\_\_\_\_
10. Has the student undergone any other screening or evaluation? \_\_\_\_\_  
If so, please explain: \_\_\_\_\_
11. Are there any other special conditions or needs that you would like to bring to the School District's attention? \_\_\_\_\_

(over)

For the health and safety of your child this information will be shared with school personnel. Please sign and date this release.

Signature of Parent/Guardian: \_\_\_\_\_

Date Signed: \_\_\_\_\_

**FOR SCHOOL USE ONLY BELOW THIS LINE**

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Are all immunizations complete? \_\_\_\_\_

If not, which ones are needed? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any special needs: \_\_\_\_\_

\_\_\_\_\_

Proof of birth was: \_\_\_\_\_

Records requested on: \_\_\_\_\_

Records received on: \_\_\_\_\_

Doctor's form received: \_\_\_\_\_

Records sent from: \_\_\_\_\_

Information complete: \_\_\_\_\_

Person taking information: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewing Nurse's Initials: \_\_\_\_\_