MARLBORO CENTRAL SCHOOL DISTRICT

Health Office Information Questionnaire - Please be very specific

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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: ______________________
German Measles: ______________________
Scarlet Fever: ______________________
TB or Contact: ______________________
High Blood Pressure: ______________________
Asthmatic Condition: ______________________
Whooping Cough: ______________________
Eye/Ear Condition: ______________________
Frequent Colds/Sore Throats: ______________________
Frequent Fevers: ______________________
Heart Problems: ______________________
Any Serious Injuries: ______________________
Hospitalizations: ______________________

Diabetes: ______________________
Measles: ______________________
Rheumatic Fever: ______________________
Mumps: ______________________
Pneumonia: ______________________
Allergic Reactions: ______________________
Allergies: ______________________
Phobias: ______________________
Orthopedic Problems: ______________________
Epilepsy: ______________________
Convulsions: ______________________
Any Operations: ______________________

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

Are all immunizations complete? ____________

If not, which ones are needed? ____________ ____________

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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: ____________

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Health information registration.doc