THETFORD ELEMENTARY SCHOOL
HEALTH QUESTIONNAIRE
(to be completed by parent or guardian)

Student Name_____ Physician's name _____
Date of Birth _____ Date of last Physical Exam _____
Mother's name _____ Dentist's name _____
Father's name _____ Date of last Dental Exam _____

IMMUNIZATIONS:
All Vermont students are required by law to be fully immunized before entering a public school. If immunizations are medically contraindicated or against your religious beliefs, please request an exemption form from the Health Office. A physician's note is required for *medical* exemptions. Please bring documentation from your child's medical provider for the following immunizations.

- ☐ DTaP/DTP/Tdap: 5 doses
- ☐ Polio: 4 doses
- ☐ MMR (measles, mumps, rubella): 2 doses
- ☐ Hepatitis B: 3 doses
- ☐ Varicella (chicken pox): 2 doses

MEDICATIONS: Please list all prescription medications taken by your child, even if he/she does not receive them at school. ***Medications to be taken at school require a special form and a doctor's orders. Please inquire at the Health Office.***

MEDICATIONS	DOSE	TIMES OF DAY	REASON

ALLERGIES: Please list and describe all allergic reactions:
_____
_____

BIRTH HISTORY:
Birth Weight ___lbs ___oz Full term_____ Premature_____ Apgars_____
Please list any problems with pregnancy or birth of your child
_____
_____

DENTAL HISTORY:
Has your child been to a dentist? YES_____ NO _____
Have you had difficulty finding a dentist for your child? YES_____ NO_____
Is your child covered by dental insurance? YES _____ NO_____
Does your child take fluoride supplements? YES_____ NO_____
Any concerns or known dental problems_____

GENERAL HEALTH:
Please describe any significant health problem your child has had since birth.
_____
_____

Does your child have any social, emotional or physical challenges that may affect his/her adjustment to school? _____
_____

Is there any significant family medical history we should know about?
_____

Please explain any significant surgeries, accidents or other health concern you would like us to know about:
_____
_____
_____

Does your child eat and sleep well?_____

How would you describe your child's general state of health?_____

If your child has had any of the following health conditions, please indicate whether they are past or current concerns:

CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT
Accidents			Allergies		
Asthma			Bedwetting		
Other resp problems			Bowel problems		
Chicken pox			Dental problems		
Diabetes			Cold(more than 6/year)		
Fainting spells			Ear infections		
German measles/rubella			Fractures		
Hearing problems			Frequent headaches		
Hepatitis			Heart conditions		
Measles			Kidney/bladder issues		
Mumps			Meningitis/encephalitis		
Reye's Syndrome			Frequent nosebleeds		
Skin Conditions			Orthopedic problems		
Speech problems			Seizures		
Strep throat/tonsillitis			Frequent sore throats		
Visual problems			Frequent stomach aches		

Questionnaire completed by (signature)_____
Relationship to child_____ Date_____