ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Student Services/ St. Mary's County Health Department

STUDENT HEALTH INFORMATION

Dear Parent(s)/Legal Guardian(s):

Completion of the following questionnaire will be helpful in assuring optimal learning in school. If a health problem is present, it is important that the school nurse is informed as soon as possible. School health information is available to the school nurse and to appropriate school personnel working with the student or with a need to know. This form will be kept in the student's health record.

Thank you.

Date: _____

Name of Student: _____ D.O.B.: _____

Address: _____

School: _____ Grade: ____

Parent: Mother's Name: _____ Home Phone: _____ Work Phone: _____

Father's Name: _____ Home Phone: _____ Work Phone: _____

Name/Phone Number Of Person To Call In An Emergency If Unable To Reach Parent: _____

Name Of Student's Doctor: _____ Date Of Last Physical: _____

Date Of Last Visit: _____ Why: _____

Name Of Student's Dentist: _____ Date Of Last Exam: _____

Check if the student has any of the following health problems:

_____ Allergies (_____)	_____ Hearing Problem	_____ Height/Weight Problem
_____ Anemia	_____ Vision Problem	_____ Nutritional Problem
_____ Asthma	_____ Dental Problem	_____ Orthopedic Problem
_____ Cancer	_____ Emotional Problem	_____ Reproductive Problem
_____ Cerebral Palsy	_____ Behavioral Problem	_____ Neurological Problem
_____ Diabetes	_____ Heart Problem	_____ Seizures

Remarks: Please explain any item checked. _____

_____

_____

Check if the student has a history of any of the following:

_____ Severe Injury _____ Meningitis _____ Head Injury _____ Substance Abuse (Alcohol/Illegal Substances)

_____ Hospitalizations (Where/When/Why): _____

Remarks: Please explain any item checked. _____

_____

_____

Does the student take medication? ( ) Yes ( ) No If yes, give name/dosage of medication(s): _____

Does the student wear glasses? ( ) Yes ( ) No Does the student wear a hearing aid? ( ) Yes ( ) No

Is there anything more about this student's health that you think is important for us to know? If so, explain.

_____

_____

Would you like to schedule a conference to discuss your student's health with the school nurse? ( ) Yes ( ) No

_____

Parent(s)'/Legal Guardian(s)' Signature

PLEASE FOLD AND RETURN TO THE SCHOOL NURSE.