

**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:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Allergies ( _____ ) | <input type="checkbox"/> Hearing Problem    | <input type="checkbox"/> Height/Weight Problem |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Vision Problem     | <input type="checkbox"/> Nutritional Problem   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Dental Problem     | <input type="checkbox"/> Orthopedic Problem    |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Emotional Problem  | <input type="checkbox"/> Reproductive Problem  |
| <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Behavioral Problem | <input type="checkbox"/> Neurological Problem  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart Problem      | <input type="checkbox"/> 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.**