Northern Lehigh School District

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www.nlsd.org

SCHOOL HEALTH QUESTIONNAIRE

To Parent(s) / Guardian(s):

The information request on this form will be of assistance to the school district in determining the health status of the student and assisting them to receive maximum benefits from this education opportunity.

Student's Name: ____

Date of Birth: ________________Sex: ___ M ___F _____Other, Identifies as: ________________________________

Student's Address: ____

Parent(s) / Guardian(s) Name(s): ____

Phone number(s): ____

____

*****SIGNATURE OF PARENT / GUARDIAN COMPLETING FORM***** **Date**

ATTACH COPY OF IMMUNIZATION RECORD

Name of Student's Physician: ____ Phone: ____________________

Name of Student's Dentist: ____ Phone: ____________________

1. Was the student's hearing ever tested? ___YES ____NO

   If YES, when? _____________ Name of Examiner: ____

   Results: ____

2. Has the student ever had an eye examination? ___YES ___ NO

   If YES, when? _____________ Name of Examiner: ____

   Were glasses prescribed? ___YES ____NO Must the child wear them constantly? ___YES____NO

3. List Medications, herbal supplements/home remedies currently being taken:

Medication Name	***Dosage***	***How often***

4. List Hospitalizations and/or Surgeries:

Date	***Description of why hospitalized / type of surgery***

5. Tuberculosis Skin Test: ____ Never had one ____ Negative Test ______ Year ____Positive Test ______ Year

6. Does the student have an Epi Pen / Epi Pen Jr. ___YES ___ NO

CONTINUE ON OTHER SIDE → → →

7. Was there any complication during pregnancy and / or labor / delivery? ___YES ___NO
   If YES, Explain: ____
8. Is the student presently under medical treatment? ___YES ____NO
9. Has the student had any serious accidents? ___YES ____NO
   If YES, explain: ____
   ____
10. Describe briefly, any traumatic events that the student has experience (for example: death of close relative, divorce, family crisis, etc.): ____
    ____
    ____
11. List specific Allergies and Treatment: ____
    ____
    ____
    ____

Health History, Include Infancy & Early Childhood History

Check below any of the following illnesses / conditions the student has had. Indicated approximate date of onset (first symptoms) and explain, treatment and health professionals involved.

Check		***Check***		***Check***	
	Arthritis		Difficulty with dressing self		Mumps
	Asthma		Diphtheria		Nail biting
	Bedwetting		Ear Infections		Negative reaction to affection
	Bladder Infection		Eczema		Pneumonia
	Blood disorder		Extremely tired		Polio
	Blood pressure – HIGH		Fainting		Poor coordination
	Blood pressure – LOW		Frequent headaches		Rheumatic Fever
	Bowel / Bladder problems		Frequent stumbling / falling		Rubella (German Measles)
	Broken Bones		Headaches / Migraines		Scarlet Fever
	Bronchitis		Heart Murmur		Seizures / Convulsions
	Cancer		Heart Problems		Short Attention Span
	Chickenpox		Hepatitis		Speech is not clear
	Concussion		High Fever		Stuttering
	Defiance of authority		Hives		Temper tantrums
	Diabetes		Hyperactivity		Thyroid Disease
	Difficulty cutting with scissors		Influenza		Tonsilitis
	Difficulty expression needs		Kidney Disease		Tuberculosis
	Difficulty holding a pencil		Malaria		Typhoid
	Difficulty playing with peers		Measles		Unusual fears
	Difficulty separating from parent(s) / guardian(s)		Meningitis		Unusual tics / twitches
	Difficulty understanding directions		Mono		Whooping Cough
	Other:		Other:		Other:

Comments: ____
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