HEALTH QUESTIONNAIRE

Pupil: ____ Grade: _____________ Date of Birth: _____________
Last Name First MI

Street Address: ___________________________________ City/State: _____________________ Zip: _________

Father's Name:____________________________________ Phone:_____________________________________

Place of Employment: ______________________________ Phone:_____________________________________

Mother's Name: ___________________________________ Phone:_____________________________________

Place of Employment: ______________________________ Phone:_____________________________________

Physician: ____ Phone:_____________________________________

Hospital Preference: ____

Dentist: ____ Phone:_____________________________________

PHYSICAL HISTORY	YEAR
Accident-Serious	
Allergy* - Drug/Other	
Asthma*	
Blood Disorder	
Cardiac Disease/Problem	
Chicken Pox (date required)	
Congenital Deformity	
Diabetes	
Hearing Loss	
Hypertension	
Illness – Serious	
Scarlet Fever	
Neurological Disorder	
Otitus Media (Ear Infection)	
Rheumatic Fever	
Seizure Disorder (Epilepsy) **	
Surgery** - Serious	
TB Contact	
Urinary Problem	
Vision Loss	
Daily Medication	
INJURIES	
Head**	
Back**	
OTHER	
COMMENT(S):	

REQUIRED SCREENING

I understand the following screenings will be provided to my child as required: vision, hearing, scoliosis and Acanthosis Nigricans. The school will follow the required screening schedule.

Parent/Guardian Signature: ____Date: ____________________

* Please indicate an **"M"** for moderate or an **"S"** for severe.
** Details needed, please use **COMMENTS** section