WICOMICO COUNTY BOARD OF EDUCATION HEALTH QUESTIONNAIRE

To assist your school nurse to better care for your child while at school, please complete this questionnaire accurately and completely and **return it to your school nurse promptly**. It will alert your school nurse to any needs your child may have while in school. This form will be kept in the nurse's office. If any information changes during the school year, please advise your school nurse. Feel free to use the back of this form for additional information. Thank you.

Child's Complete Name ____Date of birth_________ Grade_______________
Last First Middle

Child's Address ____ School ___________________ Teacher_______________
Street City State ZIP

Parent/Guardian name and **CORRECT** phone number, with area code, to be reached **during school hours**:

Mother____ Phone ( )____________________

Additional phone numbers: ( )____________________Phone ( )____________________

Father____ Phone ( )____________________

Additional phone numbers: ( )____________________Phone ( )____________________

Guardian____ Phone ( )____________________

Additional phone numbers: ( )____________________Phone ( )____________________

Please provide the name, relationship to child, address and CORRECT phone numbers for authorized persons to contact during school hours in an emergency or if child is sick and parent/guardian cannot be reached:

______________________________ ______________________________ ______________________________

Name/Relationship to child Address Phone (Home/Cell/Work)

______________________________ ______________________________ ______________________________

Name/Relationship to child Address Phone (Home/Cell/Work)

Please provide child's previous school or daycare provider:

Name______________________________ Address______________________________________ Phone_______________

Child's doctor________________________________ Phone____________________

Is the doctor named above to be contacted in an emergency if we are unable to locate parent/guardian? Yes___ No___

Will your child be taking medication in school? If so, what? ____

Will your child need an emergency medication at school (such as an epi-pen or emergency asthma medication)? Yes___ No___

NOTE: A COMPLETED PHYSICIAN'S ORDER MUST ACCOMPANY ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATION TAKEN IN SCHOOL. ALL MEDICATIONS MUST BE BROUGHT IN BY THE PARENT, GUARDIAN OR RESPONSIBLE ADULT IN THE ORIGINAL CONTAINER. MEDICATIONS BROUGHT IN BY CHILDREN WILL BE CONFISCATED AND PARENTS CONTACTED.

Does your child have any of the following? Use back of form if needed to provide further information:

___Allergies. If so, what is the allergen?____________________ How does your child react to it?____________________

___Diabetes ___Frequent nose bleeds ___Urinary condition ___Bowel condition

___Asthma ___Eyeglasses/Contacts ___Surgeries ___ Hearing aid or difficulty hearing

___Seizures ___Frequent ear infections ___ADD/ADHD ___Difficulty with speaking

___Bleeding disorder ___Frequent headaches ___Neurological condition

___Heart condition ___Learning difficulty ___Other ______________________________

___Assistive devices (such as wheelchair, feeding tube, tracheostomy, communication devices):____________________

___Restrictions on physical activity in gym or school. If so, please describe____

____

Signature of parent/guardian Date