HEALTH QUESTIONNAIRE & EMERGENCY FORM

**** PLEASE RETURN TO THE SCHOOL NURSE ****

DATE: ________________________

GRADE: ________________________

STUDENT NAME: ____ MALE: ______ FEMALE: ________
LAST FIRST MIDDLE

ADDRESS: ____ CITY: ______________ ZIP: ______________

HOME PHONE: __________________________ BIRTH DATE & PLACE: ____

MOTHER'S NAME: _______________________________ FATHER'S NAME: _______________________________

PLACE OF BUSINESS: ___________________________ PLACE OF BUSINESS: ___________________________

WORK PHONE & HOURS: __________________________ WORK PHONE & HOURS: __________________________

CELL PHONE: __________________________________ CELL PHONE: __________________________________

IF PARENTS ARE SEPARATED OR DIVORCED, WHO HAS CUSTODY?

CUSTODIAL PARENT/GUARDIAN: ____

DO NOT RELEASE TO: ____

(IF CHILD CANNOT BE RELEASED TO A NON-CUSTODIAL PARENT LEGAL DOCUMENTATION MUST BE SUBMITTED.)

SIBLINGS' NAME & DATE OF BIRTH: 1. ___________________________________ 3. ______________________________

2. ___________________________________ 4. ______________________________

IF PARENTS ARE NOT AVAILABLE, IN CASE OF EMERGENCY CALL*(PLEASE PLACE NAMES IN ORDER OF WHOM YOU WOULD LIKE CONTACTED FIRST):*

NAME: ____ RELATIONSHIP: ____

ADDRESS: ____ PHONE: ______________________________

NAME: ____ RELATIONSHIP: ____

ADDRESS: ____ PHONE: ______________________________

NAME: ____ RELATIONSHIP: ____

ADDRESS: ____ PHONE: ______________________________

HEALTH HISTORY

DOES YOUR CHILD HAVE A **MEDICAL CONDITION** THAT WILL REQUIRE SUPERVISION AND/OR THAT WILL RESTRICT THEIR ACTIVITY? IF YES, PLEASE EXPLAIN: ____

____

Please note if any of the following conditions pertain to your child:

ANEMIA ____________________	**PNEUMONIA** ____________________	**KIDNEY CONDITIONS** ____________
ASTHMA/REACTIVE AIRWAY ____________	**NEUROLOGICAL CONDITION** ____________	**MONONUCLEOSIS** ____________
RHEUMATIC FEVER ____________________	**TUBERCULOSIS** ____________________	
CHRONIC RESPIRATORY PROBLEMS ________	**SEIZURE DISORDER** ________________	**HEART DISEASE** ____________
DIABETES ____________________	**SURGERIES** ____________________	
EAR CONDITIONS ____________________	**INJURIES/FRACTURES** ____________________	
DETAILS: ____________________	**ALLERGIES:** ____________________	**REGULAR MEDICATIONS: (LIST ONLY)** ____________

NAME OF PEDIATRICIAN: ____ PHONE: __________________________

I verify that the above information is true and correct.
I understand that this information may be shared with personnel involved with my child. ____
(Parent's signature)

4/12th