

**SCHOOL HEALTH QUESTIONNAIRE  
2010/2011**

**Kindergarten - Grade 8**

School \_\_\_\_\_ Grade \_\_\_\_\_  
Transfer from \_\_\_\_\_ School in City of \_\_\_\_\_  
Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Month Day Year  
Address \_\_\_\_\_ Home Telephone \_\_\_\_\_  
Father's or Guardian's Name \_\_\_\_\_  
Name of Physician \_\_\_\_\_  
Physician: Telephone Number \_\_\_\_\_  
How often does physician see your child? \_\_\_\_\_  
Name of Dentist \_\_\_\_\_  
Dentist: Telephone Number \_\_\_\_\_

**PAST HISTORY OF CHILD** (*Give year if possible*)

Chickenpox _____	Bee Sting Allergy _____	Diphtheria _____
Whooping Cough _____	Eczema, Hay Fever, Asthma _____	Rheumatic Fever _____
German Measles _____	Hives _____	Poliomyelitis _____
Regular Measles _____	Mumps _____	Scarlet Fever _____
Frequent Colds, Sore Throats _____		
Convulsions (Explain) _____		

Hospitalizations, Injuries or Serious Illnesses. (Explain and give year or age)  
\_\_\_\_\_  
\_\_\_\_\_

Any ear infections? \_\_\_\_\_ Which ear? \_\_\_\_\_ Hearing difficulty? \_\_\_\_\_  
Any vision difficulty? \_\_\_\_\_ Wear glasses? \_\_\_\_\_  
Name of Eye Specialist \_\_\_\_\_ Date of last examination \_\_\_\_\_  
Any speech difficulty? \_\_\_\_\_

Does your child eat breakfast?  
\_\_\_\_\_

Are there any eating problems? (Explain)  
\_\_\_\_\_

What time does your child go to bed? \_\_\_\_\_ Get Up? \_\_\_\_\_  
Is elimination satisfactory? \_\_\_\_\_ Is control satisfactory? \_\_\_\_\_ Bowels \_\_\_\_\_ Bladder \_\_\_\_\_

Over....

**FAMILY HISTORY**

*(Indicate any member of the immediate family who has or has had the following illnesses.)*

Tuberculosis \_\_\_\_\_ Diabetes \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_

**HEALTH PROTECTIVE MEASURES**

Tuberculin Test: Type \_\_\_\_\_ Date \_\_\_\_\_ Positive \_\_\_\_\_ Negative \_\_\_\_\_

D.P.T. 1st \_\_\_\_\_ 2nd \_\_\_\_\_ 3rd \_\_\_\_\_  
Date Date Date

Boosters \_\_\_\_\_  
Date Date

Tdap/Td Booster \_\_\_\_\_

Polio Vaccine: Date 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ Boosters \_\_\_\_\_

Hib: Date 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_

Regular Measles (1) \_\_\_\_\_ (2) \_\_\_\_\_  
Date

German Measles (1) \_\_\_\_\_ (2) \_\_\_\_\_  
3-Day (Rubella) Date

Mumps (1) \_\_\_\_\_ (2) \_\_\_\_\_ Hepatitis B: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_  
Date Date

or

MMR (1) \_\_\_\_\_ (2) \_\_\_\_\_  
Date Date

Varicella (Chicken Pox) (1) \_\_\_\_\_ (2) \_\_\_\_\_

I hereby certify that my child has had the tuberculin test and immunizations as stated above.

\_\_\_\_\_  
*Signature of Parent*

\_\_\_\_\_  
*Date*

Please complete and return to the School Office/Nurse by the first day of school.