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