WICOMICO COUNTY BOARD OF EDUCATON HEALTH QUESTIONNAIRE

To assist your school nurse to better care for your child while at school, please complete this questionnaire and return it to your school nurse promptly. It will alert your school nurse to any needs your child may have while in school. If any information changes during the school year, please advise your school nurse.

Child's Complete Name_____ _____ _____
Last First Middle Date of Birth Grade

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**:

Parent _____ Phone _____
Additional phone Numbers: _____ Phone _____
Parent_____ Phone _____
Additional phone Numbers: _____ Phone _____
Guardian_____ Phone _____
Additional phone Numbers: _____ Phone _____

Please provide 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 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 the 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

Revised 8/28/19