

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 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**:

Mother _____	Phone _____
Additional phone Numbers: _____	Phone _____
Father _____	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