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**:

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