School Name _____

SCHOOL ENTRY HEALTH QUESTIONNAIRE

Name of Student: _____ Date: _____

Birth Date: _____ Sex: Male _____ Female _____ Entering Grade: _____

Student's Doctor: _____

Address: _____ Phone: _____

Significant Medical History

In reviewing the following checklist, please provide additional information for each yes response.

Health Problems:	**No**	**Yes (explain)**
Allergies (Please List)		
Asthma		
Birth Complications		
Breathing/Respiratory Problems		
Bleeding Problems		
Chicken Pox		
Diabetes		
Fainting/Blackouts		
Fractures/Sprains		
Heart Conditions		
Hepatitis		
Hospitalizations		
Kidney/Bladder Problems		
Toileting Issues		
Operations		
Seizures		
Other Health Concerns		
Other Significant Family Medical History (i.e., diabetes, seizures, heart conditions, etc.)		

Medications your child is currently taking:

1) At home _____

2) At school _____

Vision History

Date of last eye exam: _____ By whom?_____

Glasses? _____ Contact lenses? _____

Other eye problems (i.e., muscle problem, injury, surgery): _____

_____

Special classroom consideration needed?_____

_____

Eye Specialist: _____

Address:_____ Phone: _____

Hearing History

Date of last hearing exam: _____ By whom?_____

Hearing devices? _____ Ear tubes? _____ When inserted?_____

Tubes in place?_____ Other ear problems (i.e., infection, injury):_____

Special classroom consideration needed?_____

_____

Ear Specialist: _____

Address:_____ Phone: _____

Immunization Record

Immunizations are required prior to entering school by Vermont state law. Please have your child's physician fill out the section of the medical exam form with the dates of your child's immunizations.

If your child is not immunized due to medical, religious or moral reasons, we need a signed exemption form on record in the nurse's office.

Exempt: Medical _____

Religious _____ Attach Signed Form

Moral _____

Oral Health History

Date of last dental exam: _____ Dentist: _____

Address: _____

Age first seen by dentist: _____

Current condition of teeth: Baby_____

Secondary _____

Birth Weight: _____ Incubator? _____

Describe any birth complications: _____

_____

_____

Insurance

My child is covered under our own insurance policy : Yes _____ No _____

Please circle: Blue Cross MVP Cigna Dr. Dynasaur Medicaid Other _____

Name of anyone who has been forbidden, in a court of law, to have access to this child:*

_____

*Copy to accompany school record.

Has this child experienced any social, emotional, or physical problems which may affect adjustment to school?

Signature: _____

Relationship to Child:_____

Date: _____