Regional School District #13
School Entry Health Questionnaire

Student:__________________________ **Birth Date:**_______________ **Gender:**_______________
Address:____
Mother/Guardian:__________________________ **Telephone Number:**______________________
Father/Guardian:____________________________ **Telephone Number:**______________________
Entering Grade:__________ **Last School Attended:**____
Was your child born full term? Yes ___ No___ **If no, was child born early?**____ **Late?**____
Child's Birth Weight:____
Birth Complications, if any:____
Have you or your child's physician noted any problems in your child's development to date? Yes____ No____ If yes, please explain____
Does your child have any physical disability that we need to be aware of? Yes____ No____
If yes, please explain____
Primary Doctor:_________________________ **Phone Number:**___________________________
Name of Child's Dentist________________________ **Phone Number:**________________________

Allergies Diagnosed by Physician: Food____
Medications________________________________ Bee/Insect Stings___________________________
Environment__________________ Other____
Please Describe the Allergic Reaction:____
Date of Last Allergic Reaction:____
Epipen Needed for School: Yes_____ No_____
Asthma:________________________ Medications Taken for Asthma:___________________________
Diabetes:____
Hearing/Ear Problems: Hearing Loss_____________ Frequent Ear Infections________________
Tubes in Ears_____________ Other____
History of Concussion(s): Yes______ No______
If yes, number of concussions_________ Date(s) Sustained______________________________________
Seizures or Epilepsy:____
Serious Injury/Illness:____
Surgeries:_________________________________ **Other:**_____________________________________
Vision/Eye Problems: Glasses/Contacts__________ Eye Surgery_________ Other______________
Is your child up to date on immunizations? Yes_____ No_____
Does your child take medication(s) on a regular or daily basis? Yes______ No______
Name of medication(s)____
Will your child need to take medication(s) at school? Yes______ No______
Name of medication (s)____
Major changes or stresses in your child's life that you would consider important for us to know about:____

Completed By____ **Date**_________________
Relationship to Child_________________ **Signature**____