**WOODLAND PARK PUBLIC SCHOOLS WOODLAND PARK, NJ 07424 WOODLAND PARK PUBLIC SCHOOLS MEDICAL QUESTIONAIRE**

**STUDENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRADE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAMILY DOCTOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TELEPHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAMILY DENTIST:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEPHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The school nurse would like parents of all new students to answer the following questions so the best medical care may be provided for your child.**

**1. Is your child allergic to anything, if yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Does any food, medicine or environmental items cause difficulty in breathing? Y\_\_\_\_ N\_\_\_\_\_ If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Has your child ever had a seizure or convulsion? Yes\_\_\_\_\_ No\_\_\_\_\_**

**If yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_how often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date of last seizure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Does your child take any medication, if yes, please list name and purpose for taking medication**

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**the medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. Has your child ever been hospitalized for any illness or accident? If yes, please describe what type of accident/injury your child was treated for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. Has your child every had a head injury, fractures, or broken bones? If yes, please describe**

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**Vision \_\_\_\_\_ Hearing \_\_\_\_\_ Speech \_\_\_\_\_ Physical Activity \*Please explain if you checked any of above 10. Is there a family history of heart problems, cancer or diabetes? Yes \_\_\_\_\_ No \_\_\_\_\_ 11. Is your child afraid of anything? (i.e. animals, dark, thunder) Yes \_\_\_\_\_ No \_\_\_\_\_**

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**have an ambulance transport your child to the emergency room? Yes \_\_\_\_\_ No \_\_\_\_\_**

**14. Has your child had a Lead Test? Date of Test \_\_\_\_\_\_\_\_\_\_\_\_\_What was the level?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Signature Date**

School Year 20\_\_ - 20\_\_\_