LINDENWOLD PUBLIC SCHOOLS
Medical Questionnaire

Student's Name ___________________________________ Date of Birth _________ Grade ______ Teacher ____________________

Allergic to food, medication or insect stings? __________ If yes, please explain: ____

Did or does your child have a history of any of the following? If yes, indicate the year the problem occurred.

YES	NO		YEAR
____	____	Experienced loss of consciousness after an injury?	______
____	____	Significant hearing loss in one or both ears? Rt. _____ Lt. _____	_____
____	____	Weakness or loss of consciousness or heat exposure?	______
____	____	Have to stop when running a half mile?	______
____	____	Wear glasses or contacts during play?	______
____	____	Serious eye injury or retinal detachment?	______
____	____	Tubes in the ears or a perforated ear drum?	______
____	____	Foot/ankle problem, including sprains or recurrent pain or swelling?	______
____	____	Recurrent shoulder pain? Rt. ____ Lt. ____	______
____	____	Wrist problems, including sprains or recurrent swelling or pain? Rt. __ Lt. __	______
____	____	Wears dental appliances (braces, retainer/s, false teeth)?	______
____	____	Asthma or significant problem with allergies?	______
____	____	Health problems, chest pain, palpitations?	______
____	____	Lightheadedness or fainting with strenuous activities?	______
____	____	Muscle pulls or strains? If yes, where? _________________________	______
____	____	Epilepsy?	______
____	____	Thyroid or adrenal problem?	______
____	____	Skin problem or rash?	______
____	____	Low back pain or strain?	______
____	____	High blood pressure?	______
____	____	Neck or spine injury?	______
____	____	Any Fracture? Where __________________	______
____	____	Bleed easily/take long to stop?	______
____	____	Diabetes?	______
____	____	Hip problems? Rt__ L__	______
____	____	Undescended or absent testicle? Rt__ L__	______

Explain any significant health problem____
____

Is there a history of sudden death in the family? Yes ____ No ____

List all hospitalization and/or surgery ____
____

If the student is now under the care of a physician, please explain ____
____

If the student has been advised against participation in physical activities due to medical reasons, please explain _____________
____

List any medications your child takes regularly ____
____

Female students

Does your daughter have problems with menstrual regularity? Yes ____ No ____

Does she have disabling cramps with her periods? Yes ____ No ____

- ***I do____ do not _____ give the school nurse permission to share medical information on a need to know basis with appropriate school staff.***
- ***I hereby state that to the best of my knowledge, my answers to the above questions are correct.***

______________________________ ____ __________

Signature of Parent/Guardian   Print Name of Parent/Guardian   Date

Revised 2/11

Return to school nurse