Lumberton Township School Health Office

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Student Medical Questionnaire

_______________________________________ __________ ________________ __________
Child's Name Sex Date of birth Grade

_______________________________________ _______________________________________
Mother's Name Father's Name

Child resides with ____________________ Home/Cell Number____________________________

PERINATAL AND DEVELOPMENTAL HISTORY

Did the mother have any unusual problems/illness during the pregnancy
or the birth, such as breech, forceps or cesarean deliver? Yes _____ No _____
If yes, explain briefly: ____
____

Was the infant born: Full term _____ Early _____ Late _____ Birth weight ________

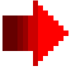
Did the infant have any sickness or problems while in the hospital,
such as yellow jaundice, blue spells or convulsions? Yes_____ No______ If yes, explain briefly:
____
____

Please give approximate age at which the child:
Sat up alone ______________________________ Said single words ____________________________
Walked ___________________________________ Spoke in sentences __________________________
Was toilet trained _________________________ Slept through the night _____________________

HEALTH CONDITIONS (please check all that apply)

_____ ADD/ADHD
_____ Asthma (Due to:)
___ Allergies ___ Exercise ___ Illness
_____ Bleeding/Clotting disorder
_____ Chicken Pox (year________)
_____ Constipation/Wetting Concerns
_____ Deformities/Birthmarks
_____ Diabetes
_____ Ear Infections/Tubes
_____ Frequent/Heavy Nosebleeds
_____ Heart Problems
_____ Hearing Problems
_____ Kidney Disorder
_____ Neurological Disorder
_____ Past Concussions/Skull Fractures
_____ Respiratory Disorder
___ Bronchitis ___ Pneumonia
_____ Seizures
Date of Last Seizure_____________
_____ Skin Disorder
_____ Speech Concerns
_____ Tuberculosis (TB)
_____ Vision Problems

If you checked any of the above conditions, please explain:
____
____



ALLERGIES AND ASTHMA

Please list and describe allergies or reactions to:
Medicines/Drugs____
Foods/Plants____
Bee/Wasp/Insect stings____
How many times has child been treated in the emergency room for an allergic reaction?_________________
What treatment did your child receive?____
Has your child been tested by an allergist?_________ If so, what type of testing has been done? __________
____
____
Does this child have asthma that has been diagnosed by a doctor? Yes _____ No____
If yes, what treatment has been prescribed? ____
____

INJURIES, ILLNESSES AND SURGERIES

Injuries, Illnesses, Surgeries	Age of Child	Check if hospitalized
______________________________	____________	____________
______________________________	____________	____________

ADDITIONAL INFORMATION

What medications are given daily? ____

What medications are given frequently, but not daily? _______________________________

Do you have any other comments or concerns about your child's health, development, behavior, family or home life that you would like the school personnel to be aware of? If yes, please explain: _____________
____
____
____

Do you have an appointment scheduled for your child's next physical? ____________
Date of appointment_________________

I am aware that pertinent medical information may need to be shared with staff members directly responsible for my child's safety and welfare.

_______________________________________ _________________

Signature of Parent or Guardian *Date*