

Brunswick School Department
HEALTH QUESTIONNAIRE
(to be filled out by parent/guardian)

Student's Name _____ Grade _____ DOB _____
Mother/Guardian _____ Phone _____
Father/Guardian _____ Phone _____
Primary Physician _____ Date of Last Physical Exam _____
Dentist _____ Date of Last Dental Exam _____
Today's Date _____ Date Attending First Class _____
Name and State of Last School Attended _____

PLEASE CHECK ALL THAT APPLIES OF YOUR CHILD

- | | |
|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Frequent Headaches/Migraines | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Mental Health Problems | <input type="checkbox"/> Seizure Disorder /Epilepsy |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Diabetes |

Comments _____

☐ Other chronic Health concerns (specify) _____

☐ Allergies (food, medication, environment, insects) Explain _____

Epi-Pen used? _____ Yes _____ No Benadryl used _____ Yes _____ No

IN THE **PAST YEAR** HAS YOUR CHILD ... (Please explain all yes responses below)

had any serious illness?	Yes _____	No _____
had any serious injuries?	Yes _____	No _____
had mental health problems?	Yes _____	No _____
been hospitalized?	Yes _____	No _____
had surgery?	Yes _____	No _____

Comments _____

LIST ALL MEDICATION, WITH DOSE, TAKEN BY YOUR CHILD

At Home _____

At School _____

Does student wear glasses?	Yes _____	No _____
Does student wear contact lenses?	Yes _____	No _____
Does student wear hearing aids?	Yes _____	No _____
Does student have a history of hearing problems?	Yes _____	No _____

Do you have any concerns about your child's eating habits?	Yes _____	No _____
Do you have any concerns about your child's sleep pattern?	Yes _____	No _____
Does your child have any physical restrictions?	Yes _____	No _____

Comments _____

Are there any family situations that may affect your child that we should be aware of? (illness, divorce, deployment)

Signature of Parent/Guardian
(rev. 03/05)