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
____
____
5. Will your child be taking any medication at school on a daily basis, if yes, please list name of 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 –
____
8. Has your child ever had any surgery? If yes, please list
____
9. If there is a problem with (please check any that apply)
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 _____
____
12. Does your child have any problems or illness? Yes _____ No_____ If yes, please note –
13. If your child is seriously injured, and school personnel is unable to contact you, may school personnel 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__