

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