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

☐ ADD/ADHD
☐ Frequent Headaches/Migraines
☐ Mental Health Problems
☐ Scoliosis
☐ Heart Condition
☐ Asthma
☐ Seizure Disorder /Epilepsy
☐ 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)