Whitehall Coplay School District
Health Questionnaire

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Previous School Attended District County State

Child's Name____ Sex______ Birthdate________
Last First MI

Address____ Telephone______________________

Father's Name_____________________________ Father's Address___________________________

Mother's Name_____________________________Mother's Address___________________________

Person with whom student lives if other than Parent:____________________ Relationship___________

Language(s) spoke at home:_____________________ Number of people living in the home__________

Child's Physician_______________________ Address_______________ Phone number ____________

Please check if your child has had any of the following: Please give details if checked.

____ chicken pox (date) ____
____ headaches ____
____ seizures ____
____ loss of consciousness ____
____ severe nosebleeds ____
_____vision problems ____
_____glasses/contacts ____
_____eye problem ____
_____hearing defect ____
____ frequent earaches ____
_____ frequent sore throats ____
_____ allergy to what? food ____
_____ allergy to what?meds ____
_____ asthma/medications ____
_____seasonal allergies/medication taken ____
_____speech problems (therapy?) ____
_____ heart murmur (restrictions?) ____
_____ frequent upset stomach ____
_____ vomiting ____
_____ diarrhea or constipation ____
_____ frequent urination ____
_____ pain/burning/urination ____
_____ bed wetting ____

Student Name: ____

_____ backache ____
_____ muscle weakness ____
_____ birth defects ____
_____serious accidents ____
_____broken bones____
_____childhood diseases____
_____ operations (type/date) ____

Is your child taking any medications: If yes, name, reason and dosage ___________________________

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List any health problems, emotional problems or other problems you or your physician feel the school should know. Please indicate if you would prefer a personal conference with the nurse to discuss this.

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All information is confidential and will be kept in the nurse's office.

Feel free to call the school nurse anytime that you need help.

_______________________ ______________________________
Date Parent/Guardian Signature