

HEALTH QUESTIONNAIRE & EMERGENCY FORM
PUPIL PERSONNEL SERVICES - LANCASTER CENTRAL SCHOOLS

NAME: _____

GRADE: _____

**** PLEASE RETURN TO THE SCHOOL NURSE ****

DATE: _____

STUDENT NAME: _____ MALE: _____ FEMALE: _____

ADDRESS: _____ CITY: _____ ZIP: _____
LAST FIRST MIDDLE

HOME PHONE: _____ BIRTH DATE & PLACE: _____

TEACHER: _____ GRADE: _____ HMR: _____

MOTHER'S NAME: _____ FATHER'S NAME: _____

PLACE OF BUSINESS: _____ PLACE OF BUSINESS: _____

HOURS & WORK PHONE: _____ HOURS & WORK PHONE: _____

CELL PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____ EMAIL ADDRESS: _____

DAYCARE / SITTER: _____ PHONE: _____

IF PARENTS ARE SEPARATED OR DIVORCED, WHO HAS CUSTODY?

CUSTODIAL PARENT/GUARDIAN: _____

ADDRESS: _____ PHONE: _____

SIBLINGS' NAME & DATE OF BIRTH: 1. _____ 3. _____
2. _____ 4. _____

DO NOT RELEASE TO: _____

(If child cannot be released to a non-custodial parent legal documentation must be submitted.)

IF PARENTS ARE NOT AVAILABLE, IN CASE OF EMERGENCY CALL:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

WE MAY HAVE OCCASION TO HAVE YOUR CHILD INCLUDED IN A NEWS ARTICLE, PHOTO / VIDEO TO BE USED FOR PUBLICITY FOR OUR SCHOOL. PLEASE INDICATE IF THIS IS ACCEPTABLE TO YOU. YES _____ NO _____

TO BE COMPLETED ONLY IF YOUR CHILD IS NEW TO LANCASTER. SCHOOL TRANSFERRING FROM: _____
DID YOUR CHILD EVER ATTEND LANCASTER SCHOOLS? YES _____ NO _____
IF YES, WHICH ONE? _____ DATE: _____ GRADE: _____

HEALTH HISTORY

DOES YOUR CHILD HAVE A **MEDICAL CONDITION** THAT WILL REQUIRE SUPERVISION AND/OR THAT WILL RESTRICT THEIR ACTIVITY? IF YES, PLEASE EXPLAIN: _____

Please note if any of the following conditions pertain to your child:

ANEMIA _____	PNEUMONIA _____	KIDNEY CONDITIONS _____
ASTHMA/REACTIVE AIRWAY _____	NEUROLOGICAL CONDITION _____	MONONUCLEOSIS _____
RHEUMATIC FEVER _____	TUBERCULOSIS _____	
CHRONIC RESPIRATORY PROBLEMS _____	SEIZURE DISORDER _____	HEART DISEASE _____
DIABETES _____	SURGERIES _____	
EAR CONDITIONS _____	INJURIES/FRACTURES _____	

DETAILS: _____ ALLERGIES: _____ REGULAR MEDICATIONS: (LIST ONLY) _____

IS HE/SHE CURRENTLY UNDER THE CARE OF A MEDICAL DOCTOR? YES _____ NO _____

NAME OF DOCTOR: _____ PHONE: _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT: _____

I understand that this information may be shared with personnel involved with my child. (Parent's signature)