09-10

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

NAME: _____ **GRADE:** _____

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

DATE: _____

STUDENT NAME: _____ MALE: _____ FEMALE: _____
LAST FIRST MIDDLE

ADDRESS: _____ CITY: _____ ZIP: _____

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. _____

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

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

DO NOT RELEASE TO: _____
IF CHILD CANNOT BE RELEASED TO A NON-CUSTODIAL PARENT LEGAL DOCUMENTATION MUST BE SUBMITTED.)

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))**

5/09mmc