Teacher:_____ **Grade:** _____

HEALTH QUESTIONNAIRE & EMERGENCY FORM

PUPIL PERSONNEL SERVICES - LANCASTER CENTRAL SCHOOLS

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

DATE: _____

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

ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ BIRTH DATE & PLACE: _____

MOTHER'S NAME: _____ FATHER'S NAME: _____
PLACE OF BUSINESS: _____ PLACE OF BUSINESS: _____
HOURS & WORK PHONE: _____ HOURS & WORK PHONE: _____
CELL PHONE: _____ CELL PHONE: _____

***** PLEASE INDICATE ORDER IN WHICH YOU WOULD LIKE CONTACT TO BE MADE******

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

1. NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

2. NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

3 . NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

IF PARENTS ARE SEPARATED OR DIVORCED, WHO HAS CUSTODY?

CUSTODIAL PARENT/GUARDIAN: _____
ADDRESS: _____ PHONE: _____

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 _____	**TUBERCULOSISMIGRAINE/HEADACHES** _____	
CHRONIC RESPIRATORY PROBLEMS _____	**SEIZURE DISORDER** _____	**HEART DISEASE** _____
DIABETES _____	**SURGERIES** _____	
EAR CONDITIONS _____	**INJURIES/FRACTURES** _____	

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

NAME OF PEDIATRICIAN: _____ PHONE: _____

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

1/11jw