Mayfield City Schools

EVERY STUDENT. EVERY DAY.

Health Questionnaire To be completed by parent/guardian at the time of registration

Student's Name: _____School: _____Grade:_____
Address: _____ Phone: (_____) _____
Male☐ Female☐ Country of birth: _____ Birthdate: ___/___/___ Age: _____
What adult(s) does child live with? _____
Who is the child's legal guardian? _____
Please list this child's brothers and sisters:

Name	Age	Sex	Name	Age	Sex
1.			4.		
2.			5.		
3.			6.		

Physician's Name: _____ Date of Last Exam: _____
Dentist's Name: _____ Date of last visit: _____
Please contact the clinic staff in your school if you need assistance with medical or dental insurance coverage.

Birth History*:*

1. Did child's mother have any health problems during pregnancy? NO☐ YES☐
   If yes, please explain _____
2. Were there any health problems (injuries or complications) during birth? NO☐ YES☐
   If yes, please explain _____
3. Full term☐ Early☐ Late☐ **Weeks Gestation**: _____ **Birth weight**: _____
4. Did this child have any sickness or problems while in the nursery or during the first month of life?
   NO☐ YES☐ If yes, please explain briefly_____

Developmental History:

1. Have you had any concerns about your child's growth or development? NO☐ YES☐
   If yes, please explain _____
2. Has your health care provider expressed concern about your child's growth or development?
   NO☐ YES☐ If yes, please explain _____

Allergies: If your child has a <u>severe allergy</u> which requires medications available and/or modifications at school, additional documentation is needed; please contact the school nurse.
List any allergies, the type of reaction and the treatment recommended:
(include foods, stings, medications, topical, and airborne allergies)

_____ _____
_____ _____
_____ _____

Injuries, Diseases, & Illnesses*:* Please list and describe any serious illness or injuries

Illness / Injury	Age	✓ Hospitalized

1. Does this child have a history of / or presently under the care of a physician for any medical, emotional, or behavioral problems?
   NO☐ YES☐ If yes, please explain _____
   Are there any family health conditions or learning problems that the school should be aware of (potentially acquired conditions, such as high blood pressure, diabetes, perceptual problems, blood disorders, chromosome alterations, ADHD/ADD, etc.)
   NO☐ YES☐ If yes, please explain_____
2. Do you have any other comments or concerns about this child's home life that you would like the school, counselor, or clinic to be made aware of?_____

Medication Information:

- What medications does this child take daily? _____
- What medications are given frequently, but not daily? _____
- Does your child receive food supplements or a modified diet? _____

Mayfield City Schools Medication Policy Highlights

Mayfield City Schools discourages medication administration at school. If it is considered necessary by your physician, a form with parent consent and physician's prescription must be on file in the school clinic before the medication can be administered. This policy also includes "over-the-counter" medications. Required forms for medication administration at school are available in the school office. There are forms required for students to carry emergency rescue medications. If a student is found to be carrying any medication without the paperwork completed, it may be cause for school expulsion under the Drug Free School policy. Questions about medication administration at school should be directed to the school nurse. The complete policy is in the Student and Parent Handbook.

Immunization Record

It is required by the State of Ohio Revised Code for schools to have an immunization record on file before the student can enter/attend school. Please provide the school with a copy from your child's health care provider or a copy from your "Baby Book" immunization record. You will be notified by the clinic staff if additional information or immunizations are required.

Documentation of a TB Test for tuberculosis must be submitted for those considered "at risk" according to the CDC Risk Survey or if the student was born outside the USA.

Has your child had the chicken pox disease? NO ☐ YES ☐ Date: ___/___/___

Vision:

- Has this child had any vision problems? NO ☐ YES ☐
- Does your child wear glasses? NO ☐ YES ☐ contacts? NO ☐ YES ☐
- Has your child been seen by an eye specialist? NO ☐ YES ☐
  Eye specialist name: _____ Date of exam: ___/___/___

Hearing:

- Has your child experienced frequent ear infections? NO ☐ YES ☐
- Does this child have any problem with hearing? NO ☐ YES ☐
  If yes, please explain _____

PLEASE refer to your school's Parent and Student Handbook for the detailed Health Policies and Procedures.

READ AND INITIAL THE FOLLOWING :

- _____I have read and understand the medication policy.
- _____I have read and understand that I am responsible for providing immunization information to Mayfield City Schools.
- _____I understand any changes in the health status of my child should be reported to the school nurse.
- _____I understand my child's medical information will be communicated to appropriate staff as determined necessary by the school nurse for the safety of my child.

Completed by: _____ **Date:** ___/___/___
(Signature)

Relationship to Child: _____