CHITTENANGO CENTRAL SCHOOL
HEALTH & DEVELOPMENT QUESTIONNAIRE

LAUREN KNUTH, R.N.	BOLIVAR RD. ELEMENTARY	687-2886	FAX: 687-2881
TRACY BIEDERMANN, R.N.	BRIDGEPORT ELEMENTARY	687-2276	FAX: 633-5606
LILIANA MONDRICK, R.N.	CHITTENANGO MIDDLE SCHOOL	687-2810	FAX: 687-2801
SABRINA TUCKER, R.N.	CHITTENANGO HIGH SCHOOL	687-2916	FAX: 687-2919

To Parents:

This information is used in the School Health Program to promote and maintain student health. It will be entered on the health record and is confidential. Please complete both sides.

Student's Name_____ Sex M F Place of Birth_____

Date of Birth _____ Home Address _____Home Phone _____

Native Language Spoken In Home_____Second Language Spoken In Home_____

Parent/Guardian's Information

Parent/Guardian Name_____

Home Phone # _____ Cell Phone # _____

Place of Employment _____ Work Phone #_____

Parent/Guardian's Information

Parent/Guardian Name _____

Home Phone # _____ Cell Phone # _____

Place of Employment _____ Work Phone #_____

IMPORTANT

Should your home, work or emergency numbers change, please notify the school office immediately! Your child's health depends upon your support and cooperation in this matter.

Name of Student's doctor _____

Date of **last complete physical examination** _____

PLEASE COMPLETE BOTH SIDES

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Medical History – Give Age & Any Related Details

Allergies _____

Asthma _____

Bee/Insect Sensitivity _____

Diabetes _____

Earaches/Hearing Problems _____

Fractures _____

Frequent Stomach Aches _____

Headaches/Migraines _____

Nosebleeds _____

Rheumatic Fever _____

Seizures _____

Toileting Problems _____

Tuberculosis _____

Vision Problems _____

Wears Glasses _____Yes _____ No

Is Any Medication Given Regularly At Home _____Yes _____ No

If Yes, for what problems? _____

Name of Medication_____ Dosage_____ When Given_____

Any Other Serious Illness or Accidents?_____

Surgery? (Dates)_____

Are there any other health issues, which might affect school performance? Attendance?

_____

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