New Prairie United School Corporation

PARENT HEALTH QUESTIONNAIRE

To be answered by parent:

NAME OF CHILD: ______________________________ Date of Birth: ________

Father: ______________ Mother: ______________ Phone: ______________

Address: House No: __________ Road: ______________________________

Diseases child had or has?:

	YEAR
Chickenpox __________	
child in a family of children.	________
Measles (14 Day) __________	________
(3 Day) __________	________
Mumps __________	________
Scarlet Fever __________	________
Whooping Cough __________	________
Rheumatic Fever __________	________

EARLY DEVELOPMENT:

This child is ____ ____

Insert accurate age in the following spaces:

Began to sit up at ______ months;

Began to walk at ______ months;

Began to say words at ____ months.

Allergies: ______________________________

____

Has child had any operations? Give kind and date: ______________________________

____

Has he/she had a serious accident? Explain: ______________________________

____

If he/she has any of the following defects or conditions, explain briefly:

Hearing loss: ______________________________

Speech defect: ______________________________

Convulsive seizures: ______________________________

Vision defect: ______________________________

Is there any condition present which should be considered in planning your child's school program?

____

____

PLEASE RETURN THIS RECORD AND INFORMATION ON OTHER SIDE COMPLETED BY YOUR PHYSICIAN TO SCHOOL.

Date: ______________ Parent's Signature: ______________________________

YOUR PHYSICIAN'S NAME (Please print) ______________________________

New Prairie United School Corporation

PHYSICAL EXAMINATION

Name: ______________________________ Grade: __________

School: ______________________________ Date of Birth: __________

Nutrition: Height __________ Weight __________

Overweight __________ Underweight __________

Eyes: ______________________________

Glasses: ______________________________

Ears: ______________________________

____

Nose: ______________________________

____

Throat: ______________________________

____

Chest: ______________________________

Heart: ______________________________

____

Blood Pressure: ______________________________

Posture: ______________________________

Scoliosis: ______________________________

Hernia: ______________________________

Feet: ______________________________

Urinalysis: ______________________________

Sugar: __________ Albumin: __________

Physically fit to participate in physical education program:

Yes __________ No __________

Physically fit for competitive sports?

Yes __________ No __________

Immunization Record

Hepatitis B Series:

1. __________ 2. __________ 3. __________

Varicella (Chicken Pox) Vaccine or date of disease:

____

Hepatitis A 1. __________ 2. __________

D.P.T. Series (Month, Date, Year)

1. __________ 2. __________ 3. __________

4. __________ 5. __________

D.T. ______________________________

Polio

1. __________ 2. __________ 3. __________

4. __________ 5. __________

Measles: ______________________________

Rubella: ______________________________

Mumps: ______________________________

MMR #1: ______________________________

MMR #2: ______________________________

HIB Vaccine: ______________________________

T.B. Test Date: __________ Type: __________

Neg: __________ Pos: __________

If Positive:

Size of Induration of MM: __________

X-ray: ______ Date: ______ Findings ______

Sickle Cell Testing Date: ______ Results: ______

Lead Poison Testing Date: ______ Results: ______

Immunization: Has this child had complete primary and booster immunization?

____

____

____

Date: ______________________________ Physician: ______________________________