Madison Local School District
Student Health Questionnaire

School NES SES MMS MHS MPK

Child's Name: _____ Grade: _____ Date of Birth: _____

Phone Numbers: Home - _____ Cell - _____ Work - _____

Medical History: Has your child had any of the following illnesses? If so, give approximate dates.

Chicken Pox - _____ Measles (Rubeola) - _____ German Measles - _____
Mumps - _____ Polio - _____ Eczema - _____
Asthma - _____ Heart Condition - _____ Rheumatic Fever - _____
Frequent Colds - _____ Sore Throats - _____ Diabetes - _____
Allergies – Foods (please list) _____
Bee Stings - _____ Other - _____

Explain symptoms & treatment - _____

Is your child on any medications? No Yes If yes, Explain _____
List all medications and dosage _____

Convulsions / Seizures No Yes If yes, Explain _____
Hospitalizations (reasons & dates) _____
Serious illness or injuries _____
Orthopedic Problems _____

Ear Problems No Yes Tubes? No Yes Hearing Difficulty? No Yes

**Speech Difficulty? No Yes Has Child ever attended speech classes? No Yes
If Yes, when and where? _____

Vision Problems? No Yes Explain any Corrections _____

Other Medical Conditions (cancer, hepatitis, bleeding disorder, etc.) _____

Has any member of the immediate family had any of the following? Diabetes - No Yes Tuberculosis - No Yes

List any new immunizations your child has received in the past year _____

I authorize school personnel to apply topical treatments such as Bactine, Calamine Lotion, Vaseline or hand lotion for minor injuries, abrasions, cuts, insect bites or poison ivy.

_____ _____
Parent Signature Date

Revised 1/1/18