Burrillville School Department

Student Health Survey

Grade:	**Teacher:**	**Homeroom:**
Name:	**Date of Birth:**	**Telephone:**
Address:	**Town:**	**ZIP:**

Resides with: ☐ Mother ☐ Father ☐ Both ☐ Stepmother ☐ Stepfather ☐ Other _____

Father's Name (guardian):	**Work Telephone:**
Mother's Name (guardian):	**Work Telephone:**
Name of Family Doctor:	**Telephone:**

Siblings	Gender	Age	Grade

Does student have any know medical conditions? ☐ Yes ☐ No If "Yes", please explain

_____

Does student take any medications? ☐ Yes ☐ No If "Yes", please explain

Medication: _____ Dosage: _____ How Often? _____ For What? _____

Please fill in the year your child has had any of the following diseases or medical conditions:

- ☐ Allergies
- ☐ Asthma
- ☐ Chicken Pox
- ☐ Convulsions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hearing
- ☐ Heart
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Measles
- ☐ Mumps
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
  - ☐ Active
  - ☐ Inactive
- ☐ Visual Defect
  - ☐ Glasses
  - ☐ No Glasses
- ☐ Other _____

Please list any known current allergies:

Allergy	Reaction When Exposed

Has the student had any accidents or injuries? If so, please describe:

Date	Type	Description

Has the student had any recent operations? If so, please describe:

Date	Type	Description

Is the student undergoing any medical treatment at this time? If so, explain:

Treatment	Reason

May your child participate in a dental exam at school? ☐ Yes ☐ No

To facilitate continuity of medical care while in the school setting, I give permission for any pertinent medical information to be shared with appropriate school faculty.

_____ _____

Parent/Guardian Signature Date