

SAXON HILL SCHOOL  
SCHOOL ENTRY HEALTH QUESTIONNAIRE

Thank you for taking the time to complete this important questionnaire. The information is confidential and will be kept in your child's school health record. Please contact the Health Officer if you have any questions or concerns, or if there are any changes in your child's health or medication during the year.

Child's Full Name: \_\_\_\_\_ Entering Grade: \_\_\_\_\_  
Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Guardian's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Guardian's Address and Phone (if different from above): \_\_\_\_\_  
Guardian's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Guardian's Address and Phone (if different from above): \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Civil Union \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Remarried \_\_\_\_\_ Single \_\_\_\_\_ Other \_\_\_\_\_  
Who is this Child's Legal Guardian? \_\_\_\_\_ Child Lives With: \_\_\_\_\_  
Brothers and Sisters: Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Child's Doctor: \_\_\_\_\_ Date of Last Complete Physical Exam: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Child's Dentist: \_\_\_\_\_ Date of Last Complete Dental Exam: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Previous School Attended (if any): \_\_\_\_\_

VISION HISTORY

Date of Last Eye Exam \_\_\_\_\_ By Whom? \_\_\_\_\_  
Glasses \_\_\_\_\_ Contact Lenses \_\_\_\_\_ Other eye problems (i.e. muscle problem, surgery, injury) \_\_\_\_\_  
Special classroom consideration needed? \_\_\_\_\_  
Eye Specialist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

HEARING HISTORY

Date of Last Hearing Exam \_\_\_\_\_ By Whom? \_\_\_\_\_  
Hearing Aids/Devices \_\_\_\_\_ Eartubes \_\_\_\_\_ Date inserted? \_\_\_\_\_ Tubes in place? \_\_\_\_\_ Other ear problems (i.e. infection, injury) \_\_\_\_\_  
Special classroom consideration needed? \_\_\_\_\_  
Ear Specialist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

SPEECH HISTORY

Does this child have speech problems that are of concern to you? Yes \_\_\_\_\_ No \_\_\_\_\_  
Has this child had an evaluation for speech or language problems? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes to either, please explain: \_\_\_\_\_  
Evaluator: \_\_\_\_\_ Date last seen: \_\_\_\_\_

IMMUNIZATION RECORD

**An up to date record of this child's immunizations MUST accompany this form. It is Vermont State law that all children have their immunizations up to date and their records on file BEFORE entering school.**

ORAL HEALTH HISTORY

Date of Last Dental Exam: \_\_\_\_\_ By Whom? \_\_\_\_\_  
Orthodontics/braces? \_\_\_\_\_ Orthodontics/Specialists: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Other oral health problems (i.e. surgery, injury) \_\_\_\_\_

OTHER SIGNIFICANT MEDICAL HISTORY

In reviewing the following checklist please provide additional information for each yes response.

| Health Problems  | No | Yes | Explain (if yes) |
|--|----|-----|------------------|
| Allergies (please list): food, environmental, medication, stinging insects |    |     |                  |
| Asthma (wheezing)  |    |     |                  |
| Breathing Problems   |    |     |                  |
| Bleeding Problems/Anemia   |    |     |                  |
| Bowel Problems   |    |     |                  |
| Chickenpox   |    |     |                  |
| Diabetes   |    |     |                  |
| Emotional Concerns   |    |     |                  |
| Fainting/Blackouts   |    |     |                  |
| Fractures/Sprains  |    |     |                  |
| Frequent Colds, Sore Throats, Ear Infections                               |    |     |                  |
| Heart Conditions   |    |     |                  |
| Hepatitis  |    |     |                  |
| Kidney/Bladder Problems  |    |     |                  |
| Menstrual Problems   |    |     |                  |
| Operations   |    |     |                  |
| Seizures/Convulsions   |    |     |                  |
| Skin Conditions (eczema, rashes, etc.)                                     |    |     |                  |
| Smokers in Household   |    |     |                  |
| Frequent School Absences   |    |     |                  |

Past Hospitalizations (explain): \_\_\_\_\_  
\_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Complications/Special Care at Birth (explain) \_\_\_\_\_  
\_\_\_\_\_

Medications Currently Taking:  
Names and Dosages: \_\_\_\_\_  
Reason for Medication: \_\_\_\_\_  
Name of prescribing physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Is medication to be given at school? No \_\_\_\_\_ Yes \_\_\_\_\_ **If yes, medication permission form required.**

Other Illnesses (Rheumatic Fever, Pneumonia, Scarlet Fever, etc.): \_\_\_\_\_  
\_\_\_\_\_

Other Significant Conditions: \_\_\_\_\_  
\_\_\_\_\_

Has this child experienced any social, emotional or physical problems that may affect adjustment to school or limit school activities? \_\_\_\_\_  
\_\_\_\_\_

Is there any significant family medical history that we should know about (i.e. diabetes, seizures, heart disease, cancer, high blood pressure, etc.)? \_\_\_\_\_  
\_\_\_\_\_

Other Comments: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature - Relationship to Child

