STUDENT I.D.# _____ DATE _____

SCHOOL NURSE MEDICAL QUESTIONNAIRE

THIS QUESTIONNAIRE MUST BE COMPLETED BY THE SCHOOL NURSE AND IS A REQUIRED "pdf" ATTACHMENT TO THE ONLINE STUDENT APPLICATION.
Website: https://esdbocesportal.lhric.org/pnwboces

STUDENT _____ HOME SCHOOL _____

DOCTOR'S NAME _____ DOCTOR'S TELEPHONE NO. _____

DENTIST'S NAME _____ DENTIST'S TELEPHONE NO. _____

CURRENT CONDITION(S) _____

NAME OF MEDICATION(S) AND DOSAGE _____

DATE OF LAST TETANUS _____ IMMUNIZATIONS UP-TO-DATE? _____

NAME AND TELEPHONE NUMBER IN CASE OF EMERGENCY:

FIRST CONTACT: SECOND CONTACT:

NAME _____ NAME _____

PHONE NUMBER _____ PHONE NUMBER _____

HAS STUDENT HAD ANY OF THE FOLLOWING? IF YES, PLEASE EXPLAIN IN SPACE BELOW:

1.	EPILEPSY OR SEIZURES	☐ Yes	☐ No	IF YES:	GRAND MAL	☐ Yes	☐ No
					PETIT MAL	☐ Yes	☐ No
2.	ASTHMA	☐ Yes	☐ No				
3.	ALLERGIES	☐ Yes	☐ No	IF YES, LIST:	_____		
4.	BEE STING REACTION	☐ Yes	☐ No	IF YES:	INJECTION	☐ Yes	☐ No
					ORAL MEDICINE	☐ Yes	☐ No
					HOSPITAL	☐ Yes	☐ No
5.	DIABETES	☐ Yes	☐ No	IF YES:	INSULIN	☐ Yes	☐ No
6.	HEART DISEASE	☐ Yes	☐ No				
7.	HEAD INJURY	☐ Yes	☐ No				
8.	KIDNEY DISEASE	☐ Yes	☐ No				
9.	HIGH BLOOD PRESSURE	☐ Yes	☐ No				
10	COLOR BLINDNESS	☐ Yes	☐ No				
11	PHYSICAL ACTIVITY RESTRICTION	☐ Yes	☐ No	IF YES, LIST:	_____		
12	SPECIAL CONDITIONS	☐ Yes	☐ No	WHEELCHAIR		☐ Yes	☐ No
				CRUTCHES		☐ Yes	☐ No

Additional Comments:

VISION WITHOUT GLASSES	R _____	L _____	Both _____	GLASSES	☐ Yes	☐ No
VISION WITH GLASSES	R _____	L _____	Both _____	CONTACTS	☐ Yes	☐ No
HEARING	R _____	L _____	Both _____	HEARING AIDS	☐ Yes	☐ No

Signature of School Nurse _____ Date _____