

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://enrollment.xenegrade.com/pnwboces>

STUDENT _____ HOME _____

DOCTOR'S NAME _____ DOCTOR'S TELEPHONE _____

DENTIST'S NAME _____ DENTIST'S TELEPHONE _____

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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | IF YES: | GRAND MAL | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | PETIT MAL | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. ASTHMA | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 3. ALLERGIES | <input type="checkbox"/> Yes <input type="checkbox"/> No | IF YES, LIST: | _____ | |
| 4. BEE STING REACTION | <input type="checkbox"/> Yes <input type="checkbox"/> No | IF YES: | INJECTION | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | ORAL MEDICINE | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | HOSPITAL | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. DIABETES | <input type="checkbox"/> Yes <input type="checkbox"/> No | IF YES: | INSULIN | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. HEART DISEASE | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 7. HEAD INJURY | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 8. KIDNEY DISEASE | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 9. HIGH BLOOD PRESSURE | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10. COLOR BLINDNESS | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 11. PHYSICAL ACTIVITY RESTRICTION | <input type="checkbox"/> Yes <input type="checkbox"/> No | IF YES, LIST: | _____ | |
| 12. SPECIAL CONDITIONS | <input type="checkbox"/> Yes <input type="checkbox"/> No | WHEELCHAIR | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | CRUTCHES | <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____