HEMPSTEAD PUBLIC SCHOOLS
PARENT QUESTIONNAIRE

Child's Name: _____ Birth Date: ____ /____ /____ Sex: M or F (circle one)

Mother's Name: _____ Father's Name:_____

With who does the child live? _____

Who is the Legal Guardian? _____

ALLERGIES AND ASTHMA

Please list and describe allergies or reactions to:

Medicines / Drugs: _____

Foods / Plants / Others:_____

Bee / Wasp stings: _____

Recommended treatment if allergy is severe: Allergy Shots?

_____

Does the child have asthma that has been diagnosed by a doctor? _____Yes _____No

If yes, what treatment has been prescribed?

_____

INJURIES, ILLNESSES, SURGERIES

Please list any severe injuries, illnesses, or surgeries:

Injuries, Illnesses, Surgeries	Age of Child	If Hospitalized (check Here)
_____	_____	_____
_____	_____	_____
_____	_____	_____

ADDITIONAL INFORMATION

What medications are given daily? _____

What medications are given frequently, but not daily? _____

This child is usually: _____very active / _____normally active / _____rather inactive

Do you have any other comments or concerns about your child's health, development, behavior, family or home life that you would like the school to be aware of? Please specify

_____

Completed by: _____ Date: _____/_____/_____

Relationship to Child: _____

I would like a conference with the school nurse: _____YES _____NO