LINDENWOLD PUBLIC SCHOOLS Medical Questionnaire

Is there a history of sudden death in the family? Yes No List all hospitalization and/or surgery If the student is now under the care of a physician, please explain If the student has been advised against participation in physical activities due to medical reasons, please explain List any medications your child takes regularly Female students Does your daughter have problems with menstrual regularity? Yes No Does she have disabling cramps with her periods? Yes No > I do do not give the school nurse permission to share medical information on a need to know basis with appropriate school staff. > I hereby state that to the best of my knowledge, my answers to the above questions are correct.	Student's Name		Date of Birth	Grade	Teacher	
Separtement	Allergic to food, medication	or insect stings?	If yes, please explain:			
Experienced loss of consciousness after an injury? Significant hearing loss in one or both ears? Rt Lt Weakness or loss of consciousness or heat exposure?	Did or does your child have a	history of any of the following	g? If yes, indicate the year t	he problem occi	urred.	
Experienced loss of consciousness after an injury? Significant hearing loss in one or both ears? Rt Lt Weakness or loss of consciousness or heat exposure? Have to stoy when running a half mile? Wear glasses or contacts during play?	YES	NO				YEAR
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