LAKE GEORGE CHARTER SCHOOL
SCHOOL HEALTH SCREENING QUESTIONNAIRE

School Year: 2017-18___
2018-19___
2019-20___
2020-21___
2021-22___

Name of Child: _____
Last First Middle

Date of Birth: _____ Grade: PS PS PS K 1 2 3 4 5 6 7
(Circle One)

Name of person filling out questionnaire: _____

Relationship to student: _____

1. When has this child last had a routine health exam? Date: _____

2. Has there ever been a concern about the age at which your child began: (Please write "yes" or "no" beside each developmental milestone.)
   Crawling_____ Walking_____ Talking_____ Bowel and Bladder Training_____

Please check appropriate blank:

3. Are there any major health problems in the family? No_____ Yes_____
   If yes, please comment:
   _____
   _____

4. Does your child have any chronic health conditions? No_____ Yes_____
   (Circle which one(s)): asthma, allergies, bronchitis, diabetes, frequent ear infections, heart condition, nervous disorders, seizure disorders, strep infections, ulcers, or _____
   If yes, (a) is he/she still under treatment? No_____ Yes_____
   (b) can the school health service be helpful? No_____ Yes_____
   If yes, please comment:
   _____
   _____

5. Has your child had any serious illness, operations, or injury? No_____ Yes_____
   If yes, (a) is he/she still under treatment? No_____ Yes_____
   (b) can the school health service be helpful? No_____ Yes_____
   If yes, please comment:
   _____
   _____

6. Has your child had any problem with vision? No_____ Yes_____
   Does your child wear glasses? No_____ Yes_____
   Has your child had any problem with hearing? No_____ Yes_____
   If yes, please comment:
   _____
   _____

7. Is your child on medication? No_____ Yes_____
   If yes, please state medication and directions:
   _____
   _____

   Does it need to be given in school? No_____ Yes_____
   If yes, please request a "Medications Permission" form.

8. Does your child have any disabilities? Any limitations? No_____ Yes_____
If yes, please state the problem:

_____
_____

9. Does your child have any need for special attention because of health problems? No_____ Yes_____
If yes, please comment:

_____
_____

10. **NEUROLOGICAL:**

Has your child ever had seizures?	No _____	Yes ____	Date of last seizure: _____
Does your child have frequent headaches?	No _____	Yes _____	Explain: _____
Does your child have sleeping or bedtime concerns?	No _____	Yes _____	Explain: _____
Does your child have a limited attention span?	No _____	Yes _____	
Do you think your student is distractible?	No _____	Yes _____	
Is your student impulsive?	No _____	Yes _____	

11. Has this child ever experienced any parental separations, divorces, or death? No _____ Yes _____
If yes, which? _____ Age of child at the time: _____
Please describe circumstances: _____
_____
_____
If parents are separated or divorced, How often does child see the other parent? _____
Is there anything significant about the visits? No _____ Yes _____ Explain: _____
_____

12. **Is there anything else about your child you would like to tell us?** No _____ Yes _____
Explain: _____
_____
_____