

**LAKE GEORGE CHARTER SCHOOL**  
**SCHOOL HEALTH SCREENING QUESTIONNAIRE**

School Year: 2011-12 \_\_\_\_\_  
2012-13 \_\_\_\_\_  
2013-14 \_\_\_\_\_  
2014-15 \_\_\_\_\_  
2015-16 \_\_\_\_\_

Name of Child: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Grade: PS PS PS K 1 2 3 4 5 6  
(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:

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9. Does your child have any need for special attention because of health problems? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, please comment:

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**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: \_\_\_\_\_

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If parents are separated or divorced, How often does child see the other parent? \_\_\_\_\_

Is there anything significant about the visits? No \_\_\_\_\_ Yes \_\_\_\_\_ Explain: \_\_\_\_\_

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12. Is there anything else about your child you would like to tell us? \_\_\_\_\_ No \_\_\_\_\_ Yes

Explain: \_\_\_\_\_

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