Montpelier Roxbury School District Annual Health Questionnaire - 2025 - 2026

Student's Name _____Grade _____ Teacher/TA _____
Date of Birth _____/_____/_____ Age _____

Parent/Guardian #1: Name & Relationship: _____
Address: _____
Phone numbers in the order we should call: 1 _____2 _____ 3 _____
May we leave a voicemail? Yes _____ No _____

Parent/Guardian #2: Name & Relationship: _____
Address: _____
Phone numbers in the order we should call: 1 _____2 _____ 3 _____
May we leave a voicemail? Yes _____ No _____

Contact person(s) in case a parent cannot be reached:
1 _____ Phone #1 _____ Phone #2 _____
2 _____ Phone#1 _____Phone #2 _____

Name of child's primary **doctor**: _____
__**Yes**__**No** Has your child had a comprehensive annual well-child visit within the past year? **Date of visit:**_____

Name of child's **dentist**: _____
__Yes __No Has your child had a dental exam/check-up in the last year? **Date of visit:**_____

Name of child's **eye doctor:**_____
__Yes __No Does your child wear glasses or contacts? Full time or part time use of glasses: _____
__Yes __No If yes, has your child had an eye exam within the past year?

__Yes __No Does your child have health insurance coverage?
__Yes __No If no, would you like information about health insurance options?

__Yes __No Does your child take any medication? (Continue on another sheet of paper if needed)
Name of medication _____
Reason for medication _____Prescribing physician _____
__Yes __No Will medicine be used at school?

NOTE: All medication must be in original containers. Parents/Guardians must bring medication to the school nurse and complete required paperwork. Prescription medications also require a written order from the prescriber.

__Yes __No __Don't know/Not sure Has a health professional **EVER** said your child has **asthma**?
__Yes __No __Don't know/Not sure If Yes, does your child **STILL** have asthma?

If Yes, please ask your provider for an **Asthma Action Plan** form and send a copy to the school nurse.

Please turn over the form and continue on the back.

__Yes __No Does your child have allergies? If YES, please check **and describe** below. Include treatment needed.

___ **LIFE-THREATENING ALLERGIES** _____

___ food allergies/sensitivities _____

___ medication allergies _____

___ environmental or other _____

__Yes __No Has your child had any serious illnesses or injuries?

If yes, please describe_____

Date of illness/injury_____

__Yes __No Does your child have any physical disabilities, including **speech** or **hearing**?

If yes, please explain: _____

Are there any limitations on activities? _____

__Yes __No Does your child have any other health conditions the school nurse should know about?

If yes, please describe: _____

Are there any limitations on activities? _____

__Yes __No Has your child experienced any social or emotional problems that may affect his/her adjustment to school?

If Yes, please explain: _____

_____

May the school nurse give your child the following medications (in age and weight appropriate doses)?

__Yes __No Tylenol (acetaminophen) **__Yes __No Advil/Motrin** (ibuprofen) **__Yes __No Tums** (antacid)

Student's Name _____ Date of birth _____

I understand that in the event of an accident or sudden illness, the school will try to contact me. If the school is unable to reach me, I authorize school personnel to seek emergency medical care, including transportation to CVMC or the nearest medical facility. I also understand that ambulance transportation will be at my expense.

I give my permission for (provider's name) _____ to exchange information with the school nurse regarding my child's diagnoses, treatments, medications, and immunizations. I understand that this information will be kept strictly confidential.

I understand that my child may require care during the school day for a variety of illnesses and/or injuries. I give permission to the school nurse to assess my child and offer treatment or advice as deemed necessary within the limits of their license.

Parent/Guardian signature _____Date _____

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