WESTFORD PUBLIC SCHOOLS
INFORMATION FOR STUDENT HEALTH RECORD

Name of Student:_____
First Middle Last

Address: _____ Town:_____ State:_____

Home Phone: _____ Alternate Phone: _____

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

Guardian's Name: _____

Child's Physician: _____ Tel: _____

Child's Dentist: _____ Tel: _____

Date of Birth: _____ ***Male*** *or* ***Female*** Previous school: _____

In answering the following questions please circle YES or NO

1. Has your child ever been hospitalized?	Yes	No
2. Has your child had any accidents or broken bones?	Yes	No
3. Is your child taking any medications at this time?	Yes	No
4. Has you child ever had an allergic reaction to any medications?	Yes	No
5. Has your child ever had an allergic reaction to a bee sting?	Yes	No
6. Has your child ever had an allergic reaction to any food?	Yes	No
7. Does your child have an Epipen prescribed by a health care provider?	Yes	No
8. Does your child have any other allergic reactions such as eczema?	Yes	No
9. Does you child wear glasses or have any problems with vision?	Yes	No
10. Does your child have tubes or any problems with hearing?	Yes	No
11. Does your child see a dentist?	Yes	No

12. Does your child ever faint when injured or otherwise?	Yes	No
13. Has your child ever had a seizure?	Yes	No
14. Does your child complain of headaches?	Yes	No
15. Does your child have a heart condition?	Yes	No
16. Does your child complain of stomach pains?	Yes	No
17. Does your child have a bladder or kidney problem?	Yes	No
18. Does your child have any skin problems?	Yes	No
19. Does your child have frequent nosebleeds?	Yes	No
20. Has your child ever had asthma or wheezing?	Yes	No
21. Has your child ever had an inhaler prescribed by a health care provider?	Yes	No
22. Has your child ever had swelling of any joints?	Yes	No
23. Does your child bruise easily or have prolonged bleeding?	Yes	No
24. Has your child had any marked change in weight recently?	Yes	No
25. Does your child have trouble sleeping?	Yes	No
26. Do you have any emotional or psychological concerns about your child?	Yes	No
27. Is there any medical concern you have about your child that is not listed above?	Yes	No
ARE THERE ANY MEDICAL CONCERNS YOU WOULD LIKE TO DISCUSS?	Yes	No

_____ _____ _____

Signature of Parent/Guardian | Phone Number | Today's Date:

sjp 2/11