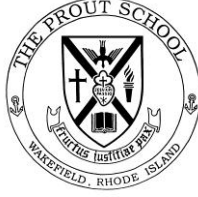


THE PROUT SCHOOL  
HEALTH QUESTIONNAIRE



To be filled out by parent and returned to school so that your child's health record can be brought up-to-date.

STUDENT'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_  
FAMILY DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

Please list any allergies and treatment needed \_\_\_\_\_  
Epi-Pen needed: \_\_\_\_\_ Reason: \_\_\_\_\_

Please list any illness your child has had this past year.  
\_\_\_\_\_  
\_\_\_\_\_

Please list any immunization or booster shots your child received this past year. Please give month, day, year.  
\_\_\_\_\_  
\_\_\_\_\_

Has your child been hospitalized this past year? If answer is yes, please state reason and length of stay.  
\_\_\_\_\_  
\_\_\_\_\_

Have any physical restrictions been placed on your child this past year or in the past?  
\_\_\_\_\_  
\_\_\_\_\_

Is he/she now able to participate fully in all physical activities? \_\_\_\_\_

Is your child taking any medication prescribed by a doctor other than vitamins? If so, please give the name of medication and how often it is given.  
\_\_\_\_\_

Has your child obtained a professional eye examination this year? If so, please indicate treatment by checking below:  
 Obtained glasses for the first time       Change of lens       Glasses not advised

Dentist: \_\_\_\_\_ Date of Last/Next Visit: \_\_\_\_\_

Has your child had any emotional problems or do you have any concerns which you feel the school should be aware of?  
\_\_\_\_\_

Please note here any pertinent data pertaining to your child's health.  
\_\_\_\_\_

**Please have Original Health Record from previous school sent to The Prout School, 4640 Tower Hill Rd, Wakefield, RI 02879. ALL PHYSICALS ARE DUE TO THE NURSE BY AUGUST 15, 2017.**