MANSFIELD PUBLIC SCHOOLS HEALTH SERVICES
New Student Information Survey
Please return to the Health Office in your child's school ***as soon as possible***

Student Name _____ Sex: F___ M___ Grade _____
First (Full Middle Name) Last

Address _____ Birth Date _____

Home Telephone _____ Birth Place _____
City State

Primary Language Spoken at Home _____

Father's Name _____ **Mother's** Name _____

Work Telephone _____ Work Telephone _____

Cell Telephone _____ Cell Telephone_____

Child resides with: □ mother □ father □ guardian □ both parents

Mother's Maiden Name _____

Is anyone in your family serving our country?____ If yes, what is relationship to student _____

*If applicable:

please indicate name/phone number of guardian: _____

please indicate name/phone number of daycare provider: _____

Physician _____

Health Insurance _____

Dentist _____

Dental Insurance_____

Siblings:
(First & Last Names) (Date of Birth)

_____

_____

_____

Health Information

SCHOOL **MUST** HAVE IMMUNIZATION FOR FIRST DAY OF SCHOOL ATTENDANCE
(Massachusetts' law requires written proof of immunizations)

Specific Illnesses and Medical Conditions

(Use the back of this sheet for explanations of any items checked below)

□ Accidents:
- □ Broken Bones
- □ Stitches

□ Allergies
□ Asthma
□ Birth History
- □ Prematurity
- □ Complications

□ Dental Issues
- □ Orthodontia

□ Diabetes
□ Genetic Disorder
□ Heart Disease
□ Kidney Disease
□ Orthopedic Issues
□ Seizures

□ Serious illnesses
- □ Hospitalization
- □ Recurrent Infections

□ Vision Problems
- □ Glasses

□ Hearing Problems
- □ Hearing Aids

□ Speech Concerns
□ Other

Does your child take any daily medications?_____/As Needed Medication? _____

The School Nurse has my permission to share this information with other staff members who work with my child.

Parent/Guardian Signature _____ Date _____