Established 1915 BROWARD County Public Schools

Healthy Schools

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2018 Well Visit Health Questionnaire Teens/Adolescents

THIS FORM MUST BE RETURNED

Please complete all the information below (illegible or incomplete forms will not be accepted).

Date Completed:

PLEASE PRINT

Full, Legal Name of Student (First Name, Middle Initial, Last Name)		Name of Child's School		
Parent/Guardian Name (First Name, Middle Initial, Last Name)	Relationship to Student	E-mail Address		
Address	Child's Grade	Child's Birth Date (month/date/year)	Child's Age	Child's Sex
City	Zip Code	Home Phone Number	Cell Phone Number	
Demographic Information: (Circle one) White American Indian/Native Alaskan Black Asian Hispanic Other				

MEDICATIONS Include all prescription and nonprescription, maintenance and as needed meds		
Name	Dose	How often
Name	Dose	How often
ALLERGIES Please specify the, reaction (hives, swelling, etc.), severity (mild, moderate or severe) and interventions (Benadryl, epi pen, etc.)		
Food:		
Insects, Animals, Other:		
IMMUNIZATIONS Up to date?		
(Circle one) Yes No Do not know		

HOUSEHOLD Please list all people living in child's home and the relationship to child.	
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Are there siblings not listed? If so, please list their names, ages, and where they live.	
What is the child's living situation, if not with both biological parents? ☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody ☐ Lives with foster family ☐ Other family member	
If one or both biological parents are not living in the home, how often does the child see the parent(s) not in the home?	

BIRTH HISTORY	
☐ Do not know birth history	
During pregnancy, did the mother:	
Smoke?	☐ Yes ☐ No
Use drugs or medications?	☐ Yes ☐ No
Drink Alcohol?	☐ Yes ☐ No

Biological Family History DK= Do not know					
Have any family members had the following?					
Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who	Comments
Nasal Allergies	☐ Yes	☐ No	☐ DK	Who	Comments
Asthma	☐ Yes	☐ No	☐ DK	Who	Comments
Tuberculosis	☐ Yes	☐ No	☐ DK	Who	Comments
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who	Comments
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who	Comments
Anemia	☐ Yes	☐ No	☐ DK	Who	Comments
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who	Comments
Dental decay	☐ Yes	☐ No	☐ DK	Who	Comments
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who	Comments
Liver disease	☐ Yes	☐ No	☐ DK	Who	Comments
Kidney disease	☐ Yes	☐ No	☐ DK	Who	Comments
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who	Comments
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who	Comments
Obesity	☐ Yes	☐ No	☐ DK	Who	Comments
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who	Comments
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who	Comments
Drug abuse	☐ Yes	☐ No	☐ DK	Who	Comments
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who	Comments
Developmental disability	☐ Yes	☐ No	☐ DK	Who	Comments
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who	Comments
Tobacco use	☐ Yes	☐ No	☐ DK	Who	Comments
Additional family history	☐ Yes	☐ No	☐ DK	Who	Comments

Student History DK= Do not know				
Does your child have, or has your child ever had:				
Chickenpox	☐ Yes	☐ No	☐ DK	When
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain
HIV	☐ Yes	☐ No	☐ DK	Explain
Organ transplant	☐ Yes	☐ No	☐ DK	Explain
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain
Dental Care every 6 months	☐ Yes	☐ No	☐ DK	Explain
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain
Metabolic/genetic disorders	☐ Yes	☐ No	☐ DK	Explain
Cancer	☐ Yes	☐ No	☐ DK	Explain
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain
Bed-wetting (10 years)	☐ Yes	☐ No	☐ DK	Explain
Obesity	☐ Yes	☐ No	☐ DK	Explain
Diabetes	☐ Yes	☐ No	☐ DK	Explain
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain
High blood pressure	☐ Yes	☐ No	☐ DK	Explain
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain

Student History (continued)				
Tobacco use	☐ Yes	☐ No	☐ DK	Explain
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain
Developmental delay	☐ Yes	☐ No	☐ DK	Explain
Dental decay	☐ Yes	☐ No	☐ DK	Explain
History of family violence	☐ Yes	☐ No	☐ DK	Explain
Girls Only—Menstrual Cycle				
Has had period	☐ Yes	☐ No	Age of first period:	
List any issues/problems associated with period				

If you have any health questions, please contact your child's pediatrician or call Healthy Schools LLC at 1-800-566-0596 to speak to a nurse.

Disclosure of SBBC Student Information:
I hereby give consent for SBBC to provide all of the information on this consent form (including medical information, demographics and contact information) to Healthy Schools for licensed healthcare providers to provide comprehensive health child check up to my child.

I voluntarily give my consent to Healthy Schools LLC and their administrators to perform a well visit examination on my child in my absence and in their professional judgment, communicate with other healthcare providers, on an as needed basis. I hereby acknowledge that no guarantee has been made to me as to the effect of such examinations on my child. IN addition, I agree that Healthy schools LLC may disclose my child's personal health information for billing and records keeping purposes, all in accordance with the applicable statutes and regulations.

☐ Yes, I want my child to have a well visit examination.

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____

Date _____