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 IMMUNIZATIONS 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
☐ Social/Emotional Concerns

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 ________________