Mansfield School Health Questionnaire

Complete every blank and return to the school nurse as soon as possible with the data and your signature.

Student Name_____
Last First Middle

Grade_____

Please circle one of the following:

Ethnic Background of your child?

Asian or Pacific Islanders
Black
Caucasian
Hispanic
Native American
Unknown or other

Type of Health Insurance (circle one): Private HMO PPO MC+/Medicaid None
Type of Dental Insurance (circle one): Private Group Plan MC+/Medicaid None
Name of Primary Care Doctor_____
Date of last complete physical_____
Reason for last visit to physician_____
Name of Primary Dentist_____
Date of last dental exam_____
Reason for last visit to dentist_____

Parent/Guardian Signature_____**Date**_____