History of Illness Questionnaire for Deering Middle School Students

The Rhode Island Department of Public Health requests that you complete this questionnaire regarding your child's health in order to help us find out if there are more illnesses in the school than usual.

Student's Last Name	**First Name**	**Middle Initial**	**Student's Date of Birth:** Month	Day	Year

Street Address:	**City**	**Zip code**	**Phone number**

1. How many people live in the same house as this student? ____

2. What is their team? ☐ Comet/Andre Grade 6 team ☐ Comet/LeCampion/Gagne/Maganelli Grade 6 team ☐ Neri/DePaolo Grade 6 team ☐ Paliotta/Maziarz Grade 6 team ☐ Knight/Tuttle 6th Grade team ☐ 7 Black team ☐ 7 Orange Team ☐ 7 White team ☐ 8 Black team ☐ 8 Orange team ☐ 8 White team

3. How many children in the home attend Deering Middle School? _____

4. Did this student go to a doctor because of *sickness* at least one time since October 1, 2006?
   ☐ Yes: *Go to the next question* ☐ No or not sure: *Thank you – the form is complete.*

5. If yes to question 4, please complete the following questions in the table for each sick visit to doctor:

Visit Date (mm/dd)	What symptoms prompted the visit?	Was a chest X-ray done?	Did the doctor say this student has pneumonia?	Were antibiotics given for treatment?
___/___	☐ Fever ☐ Cough ☐ Headache ☐ Diarrhea ☐ Earache ☐ Sore throat ☐ Other, list: ________	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure	☐ Yes—If so, what antibiotic: ☐ Azithromycin (Zithromax) ☐ Doxycycline ☐ Other ________ ☐ None ☐ Not sure
___/___	☐ Fever ☐ Cough ☐ Headache ☐ Diarrhea ☐ Earache ☐ Sore throat ☐ Other, list: ________	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure	☐ Yes—If so, what antibiotic: ☐ Azithromycin (Zithromax) ☐ Doxycycline ☐ Other ________ ☐ None ☐ Not sure
___/___	☐ Fever ☐ Cough ☐ Headache ☐ Diarrhea ☐ Earache ☐ Sore throat ☐ Other, list: ________	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure	☐ Yes—If so, what antibiotic: ☐ Azithromycin (Zithromax) ☐ Doxycycline ☐ Other ________ ☐ None ☐ Not sure
___/___	☐ Fever ☐ Cough ☐ Headache ☐ Diarrhea ☐ Earache ☐ Sore throat ☐ Other, list: ________	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure	☐ Yes—If so, what antibiotic: ☐ Azithromycin (Zithromax) ☐ Doxycycline ☐ Other ________ ☐ None ☐ Not sure
___/___	☐ Fever ☐ Cough ☐ Headache ☐ Diarrhea ☐ Earache ☐ Sore throat ☐ Other, list: ________	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure	☐ Yes—If so, what antibiotic: ☐ Azithromycin (Zithromax) ☐ Doxycycline ☐ Other ________ ☐ None ☐ Not sure

6. May we contact you if we have further questions? ☐ Yes ☐ No