

# Totowa Borough Public Schools

Memorial School

294 Totowa Road, NJ 07512

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*Patricia Capitelli*  
*Chief School Administrator*

*Lori Johnson*  
*MS Nurse*

July 17, 2022

Dear Parents/ Guardians,

The Totowa Public Schools are requiring a re-verification process for all students entering the 3rd grade. This new process is to help keep the students' medical records up to date. The re-verification process requires the completion and submission of the attached forms, and a complete vaccination record.

The specific supporting document forms can be found at our website:  
[www.totowa.k12.nj.us](http://www.totowa.k12.nj.us) under Nurses Corner or on the parent portal.

Families are required to send this information to the Nurse's office via mail or email. Please be advised, your re-verification forms and supporting documents should be received by August 15, 2022.

Thank you in advance for your cooperation during this process. If you have any questions, please feel free to contact me via email.

Sincerely,

Lori Johnson

School Nurse, RN, CSN

## HEALTH HISTORY

This questionnaire has been developed so that we might better understand your child and meet his/her individual needs. This questionnaire will be kept with your child's school medical records.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Totowa, NJ Home Phone #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Physician Phone #: \_\_\_\_\_

1. How would you describe your child's general health?  Excellent  Good  Fair  Frequently ill-
2. Has your child ever been hospitalized?  Yes  No  
If yes, please describe the reason: \_\_\_\_\_  
\_\_\_\_\_
3. Has your child ever had a traumatic injury? (Head injury, broken bones, stitches)  Yes  No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
4. Were there any complications at birth? \_\_\_\_\_
5. Are there any family illnesses which might have an effect on your child? (Diabetes, etc.) \_\_\_\_\_  
\_\_\_\_\_
6. Has your child ever had an eye exam? \_\_\_\_\_. When and results: \_\_\_\_\_
7. Does your child wear glasses?  Yes  No
8. Has your child ever had a hearing exam? \_\_\_\_\_. If yes, results: \_\_\_\_\_
9. Does your child have any allergies? \_\_\_\_\_. What specific things is your child allergic to? \_\_\_\_\_  
\_\_\_\_\_
10. Has your child ever had a severe allergic reaction which requires that medication be kept in school?  
 Yes  No. If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
11. Has your child ever had Chicken Pox disease?  Yes  No. If yes, date: \_\_\_\_\_
12. Has your child ever had the Chicken Pox vaccine (Varivax)?  Yes  No. If yes, date: \_\_\_\_\_
13. Please place a check mark next to any of the following medical problems your child has experienced:  

<input type="checkbox"/> convulsions due to high fever	<input type="checkbox"/> headaches
<input type="checkbox"/> tonsillitis	<input type="checkbox"/> ear infections
<input type="checkbox"/> tonsillectomy	<input type="checkbox"/> perforated eardrum
<input type="checkbox"/> myringotomy	<input type="checkbox"/> fluid in middle ear
<input type="checkbox"/> cauterization of nose	<input type="checkbox"/> bloody nose
<input type="checkbox"/> strep throat	<input type="checkbox"/> asthma
<input type="checkbox"/> heart dysfunction	<input type="checkbox"/> bladder infection
<input type="checkbox"/> eczema	<input type="checkbox"/> turning in or out of feet
<input type="checkbox"/> hay fever	<input type="checkbox"/> arthritis
<input type="checkbox"/> congenital hip	<input type="checkbox"/> coordination difficulties
<input type="checkbox"/> hyperactivity (diagnosed by doctor)	<input type="checkbox"/> involuntary urination ( day / night )

**( PLEASE COMPLETE BOTH SIDES )**

14. Please comment on any areas you have checked: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Does your child have any special fears or anxieties? \_\_\_\_\_. If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

16. Does your child take any medication on a regular basis? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Prescribing Doctor: \_\_\_\_\_  
Reason for this medication? \_\_\_\_\_

17. Any additional health/medical information about which we should be aware of? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I GIVE MY PERMISSION TO HAVE THE INFORMATION CONTAINED IN THIS HEALTH HISTORY  
SHARED  
WITH THE MEMBERS OF THE SCHOOL STAFF WHO ARE RESPONSIBLE FOR MY CHILD.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**TOTOWA SCHOOLS PHYSICAL EXAM REPORT**

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Date of Physical: \_\_\_\_\_

Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ B/P \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Eyes-Vision	Normal _____	Abnormal _____
Ears-Hearing	Normal _____	Abnormal _____
Nose-Throat	Normal _____	Abnormal _____
Lungs	Normal _____	Abnormal _____
Heart	Normal _____	Abnormal _____
Nutrition	Normal _____	Abnormal _____
Skeletal System	Normal _____	Abnormal _____
Skin	Normal _____	Abnormal _____
Nervous System	Normal _____	Abnormal _____

**Disease History**

Tuberculosis	Yes _____ - Date _____	No _____
Chicken Pox	Yes _____ - Date _____	No _____
Measles	Yes _____ - Date _____	No _____
AIDS	Yes _____ - Date _____	No _____
Scarlet Fever	Yes _____ - Date _____	No _____
Hepatitis	Yes _____ - Date _____	No _____
Lyme Disease	Yes _____ - Date _____	No _____

Scoliosis: >10 years old. Pos \* \_\_\_ Neg \_\_\_ Explain\* \_\_\_\_\_

Allergies that might affect school behavior or attendance \_\_\_\_\_

Describe any physical condition that might affect student's participation in the school program \_\_\_\_\_

Does this student take any medication on a regular basis? List medications \_\_\_\_\_

Has this student ever had a psychiatric exam? Identify reasons and results \_\_\_\_\_

Has this student ever had a neurological exam? Identify reason and results \_\_\_\_\_

Rate student's overall health: \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

\*Signature of examining physician \_\_\_\_\_ Date: \_\_\_\_\_

**\*OFFICIAL PHYSICIAN STAMP:**

**\*(THIS FORM IS NOT ACCEPTED WITHOUT SIGNATURE & STAMP OF PHYSICIAN)**