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:

_____ convulsions due to high fever
_____ tonsillitis
_____ tonsillectomy
_____ myringotomy
_____ cauterization of nose
_____ strep throat
_____ heart dysfunction
_____ eczema
_____ hay fever
_____ congenital hip
_____ hyperactivity (diagnosed by doctor)
_____ headaches
_____ ear infections
_____ perforated eardrum
_____ fluid in middle ear
_____ bloody nose
_____ asthma
_____ bladder infection
_____ turning in or out of feet
_____ arthritis
_____ coordination difficulties
_____ 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