SOUTH BRUNSWICK TOWNSHIP PUBLIC SCHOOLS

HEALTH HISTORY

(To be completed by parent/guardian)

Family:

Child's name: ____ Date of Birth: ___________________________

Mother's name: ____________________________________Father's name: _________________________________

Guardian's name: _____________________________________ Present marital status: ______________________

This child is # ____________of ____________children

Recent changes in family life: ____

Chronic diseases in family: ____

Medical History:

Frequent headaches: ___________ Frequent ear infections: ____________ Stomach complaints: ____________

Chicken Pox: Yes_____ No_____ Date: _____ Speech difficulties: __________ Hearing difficulties: ___________

Glasses: __________ Contacts: __________ Used to improve: Near Vision: _________ Far Vision: ________

Asthma: __________________ (If your child has asthma, please see the school nurse.)

Uses Inhaler: _______ Name of Inhaler: ____________________Uses Nebulizer: Yes__________ No__________

Allergies: ___________________________ (If allergy exists, please see the school nurse.)

Medications for allergies: _______________________________________ Epi-pen prescribed?: Yes_____ No_____

Seizures: _______________ Heart murmur: ________________ Anemia or blood conditions: ________________

Serious illness: _______________ Head Injury: ________________ Orthopedic conditions: ________________

Recent surgery: ________________________________ Hospitalizations: ________________________________

Chronic health conditions: ____

Current Status:

Routine medication(s): ____

(If medications need to be taken during school hours, please see the school nurse.)

Current activity restriction(s): ____

Is there any other information that you think would be helpful for school personnel to be aware of to best assist your student at school?: ____

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HEALTH QUESTIONNAIRE
(To be completed by student)

Student's name: ______________________________ Date of Birth: ____________________

The following is a list of conditions that sometimes offers young people concern. Check each one as to whether you are concerned by it often, occasionally, or never.

	Often	Occasionally	Never
Skin trouble (rashes or pimples)			
Headaches			
Vision problems			
Hearing problems			
Toothaches			
Stomach pains			
Loneliness			
Anger and/or temper			
Nervous or anxious			
Trouble sleeping or getting to sleep			
Tired all the time			

	Yes	No
Do you think you are a healthy person?		
Are you content with your weight and height?		
Are you content with your social life?		
Are you glad to come to school?		

List any information you want or would like the school to know about your health and well being: ________________

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