DOWNE TOWNSHIP ELEMENTARY SCHOOL

220 Main Street, Newport, NJ 08345

Heath History Form

(To be filled out by parent/guardian)

Last Name:_____ First Name:_____

Date of birth:_____ Grade:_____

Address :_____

Phone Number:_____

Medical Conditions- (Please check all that apply and explain)

__ **Allergies**
Please explain on next page

__**Asthma**_____
Triggers:_____
Year diagnosed _____

__ **Attention Deficit Disorder ADD/ADHD**
_____
Year diagnosed _____
Daily Medication:_____

__ **Bleeding Disorder**_____

__ **Bone/Muscle disorders**_____

__**Diabetes**_____

__ **Hearing/Ear, Nose, Throat**
_____

__ **Emotional Stress/ Stressors**_____

_____

__ **Eye/Vision Problems**_____

__ **Heart Problems**_____

__ **Respiratory** _____

__ **Seizures (Convulsions)** _____
__ Absence_____
__ Grand Mal_____
__ Petit Mal_____
__ Other_____

__ **Skin Problems**_____

__ **Mouth/Stomach/Intestinal Problems**
_____

__ **Bladder/Urinary**_____

__ **Surgeries** _____

__ **Other**_____

_____
Please list all medications, doses, & times student takes daily:
__ _____

_____

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Allergies:

__Food Allergies: Tree Nuts __ Peanuts __ Fruit_____ Other_____ **Year diagnosed:**_____

Reaction:_____

__Medication Allergies::_____ **Year diagnosed:**_____

Reaction:_____

__Environmental Allergies (bees, latex):_____ **Year diagnosed:**_____

Reaction:_____

__Seasonal Allergies: _____ **Year diagnosed:**_____

__ Other:_____ **Year diagnosed:**_____

Disease History

Disease	Year	Disease	Year
Chicken Pox		Seizures/Epilepsy/ Febrile Seizures (please circle)	
Diabetes		Rheumatic Fever	
Strep Infection		Mononucleosis	
Ear Infections		RSV	
Heart /Heart murmur		Other	

Does your student wear glasses? Yes / No When does your student wear glasses?_____
Does your student wear contacts? Yes / No
Has your child ever had any broken bones? Yes / No What?_____ When?_____
Is your child: Right Handed or Left Handed
At what **age** was your child toilet trained? _____

Family Physician/Pediatrician:_____

Address:_____

Telephone # _____

Date of last well visit/ check-up: _____

Dentist: _____

Address:_____

Telephone # _____

Date of last dental exam/cleaning:_____

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Birth History: If Known

Full Term:_____ Premature:_____

Birth defects:_____

Did mom have any conditions or complications during pregnancy: _____

_____

Conditions or complications at birth: _____

_____

Family History: Please explain if possible and state relation of person to student.

Heart problems:_____

High Blood Pressure: _____

Lung problems including asthma:_____

Cancer (what type)_____

Have any family members under age of 50:
Had a heart attack:_____

Had other serious health problems:_____

Please state whether the family members are deceased or living.

Please explain anything you feel is important for the School Nurse to know about your child:

_____

_____

_____

May the information from this form be shared with your child's teachers/appropriate staff? **Yes / No**
May the school nurse discuss information from this form with your child's doctor/provider? **Yes / No**

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

The information provided on this form is CONFIDENTIAL and will only be discussed with your authorization.