

Rochelle Park School District

Midland School #1

300 Rochelle Avenue

Rochelle Park, NJ 07662

Phone: 201-843-3120 Fax: 201-843-7293

STUDENT HEALTH HISTORY ENTRANCE FORM

Child's Name: _____ Sex: M ___ F ___ Birthdate _____

1. Is your child currently under the care of a medical doctor or specialist? ___yes ___no If yes, for what reason? _____

2. Has your child ever been hospitalized for illness or surgery? ___yes ___no If yes, for what reason and when? _____

3. Does your child take any medication on a daily basis? ___yes ___no If yes, what medication and for what reason? _____

4. Does your child have any condition which would restrict participation in physical education classes and/or other strenuous activities? ___yes ___no If yes, please explain. _____

5. Has your child ever experienced a head injury (minor or a concussion) from a fall or accident? ___yes ___no If yes, please explain. _____

6. Does your child have now, or has he/she ever had behavioral or emotional issues? ___yes ___no If yes, please explain. _____

7. Does your child have any allergies? ___yes ___no If yes, to what _____

8. Does your child have or ever had the following? Please give month and year if known:

___ Asthma	___ Hearing Problems	___ Pneumonia
___ Bronchitis	___ Heart Condition	___ Rashes/Eczema
___ Chicken Pox	___ Lyme Disease	___ Seizures
___ Congenital Defects	___ Mononucleosis	___ Strep Throat/Tonsillitis
___ Diabetes	___ Muscular Problems	___ Speech Impairment
___ Frequent Ear Infections	___ Neurological Problems	
___ Glasses/Contacts	___ Nosebleeds	
___ Headaches	___ Orthopedic Problems	

Any other information about the above checked off conditions please explain below:

PLEASE SEE OTHER SIDE

9. Please notify the School Nurse of any medical problems, serious illness or communicable diseases. In addition, if your child has a physical done or receives any immunizations, please provide a copy for the health office. That way his/her health record can be kept up to date. Also, please note that New Jersey law requires both doctor and parent permission for taking medication in school. Without both signed permission statements, the nurse CANNOT give the medication even if you send it to school with your child.

10. I authorize the school nurse to release information regarding health concerns/medical issues that may impact my child's safety or performance in school. ____yes ____no

Signature of Parent _____ **Date** _____

Please provide below any other additional information that the school nurse may need to know:

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