# Rochelle Park School District

## Midland School #1

**300 Rochelle Avenue**
**Rochelle Park, NJ 07662**
**Phone: 201-843-3120**
**Fax: 201-843-7293**
**Web: http://rp.bergen.org**


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### LATCHKEY PROGRAM STUDENT HEALTH HISTORY FORM

Child's Name_____ Sex ☐M ☐F Birth Date_____

**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 or ever had:

| | | | |
|---|---|---|---|
| Allergies…….....… | ☐Yes ☐No | Lyme Disease…….…. | ☐Yes ☐No |
| Asthma…… | ☐Yes ☐No | Mononucleosis……... | ☐Yes ☐No |
| Blood Disorder…...…. | ☐Yes ☐No | Muscular Problems…..… | ☐Yes ☐No |
| Bronchitis…… | ☐Yes ☐No | Neurological Problems… | ☐Yes ☐No |
| Chicken Pox…...……. | ☐Yes ☐No | Nosebleeds……...… | ☐Yes ☐No |
| Congenital Defects….. | ☐Yes ☐No | Orthopedic Problems….. | ☐Yes ☐No |
| Diabetes……...… | ☐Yes ☐No | Pneumonia……...… | ☐Yes ☐No |
| Glasses/Contacts…..… | ☐Yes ☐No | Rheumatic Fever……..… | ☐Yes ☐No |
| Headaches…… | ☐Yes ☐No | Seizures…… | ☐Yes ☐No |
| Hearing Aid……..… | ☐Yes ☐No | Serious Illness……...… | ☐Yes ☐No |
| Hearing Problems…… | ☐Yes ☐No | Speech Impairment…...… | ☐Yes ☐No |
| Heart Condition…...… | ☐Yes ☐No | Tuberculosis……..… | ☐Yes ☐No |
| Hepatitis……...… | ☐Yes ☐No | Vision Problems……..… | ☐Yes ☐No |

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If yes to any of the above, please explain_____

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_____

**8.** Birth History:

Birth Weight_____ Full Term_____ Premature_____

Were there any problems during pregnancy or birth? ☐**Yes** ☐**No**

If yes, please explain._____

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**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 any other additional information below:

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