Green Hills School Student Health History

Name: ______________________________

Date: ____________ **D.O.B.**______________ **Age:** _______ **Grade:** ________ **Sex:** **M / F**

Please mark yes or no	**Yes**	**No**	***Indicate date when possible***	**Yes**	**No**
Allergies (food, environmental, bee sting)			Mononucleosis		
Congenital Abnormalities			Mumps		
Drug Allergies or Sensitivities			Measles		
Asthma			Rubella (German Measles)		
Hepatitis			Chicken Pox		
Diabetes			Surgical Operations		
Lead Poisoning			Hospitalizations		
Seizures			Current Medications		
Heart Disease or Murmur			Toilet Trained		
Strep Infections			Behavior Problems		
Accidents/Injuries			Ear Infections		
Broken Bones/ Fractures			Tubes placed in ears		
Scoliosis			Hearing Loss		
Head Lice			Speech Problems		
Ringworm			Fainting		
Eczema			Migraines		
Dental Cavities			Vision Problems		
Pneumonia			Neurological Abnormalities		
Head Injury			Developmental Delays		
Frequent Headaches			Frequent Nosebleeds		
Frequent Abdominal Pain			Constipation		
Other:					

Is your child taking any medication(s)? ______________________________

Are there any restrictions on your child's activities? ______________________________

Are there any conditions or habits that school personnel should be aware of? ______________________________

Has your child's growth/development been normal? If no, please explain: ______________________________

During pregnancy did mother have any medical problems? If yes, please explain: ______________________________

Were there problems during labor/delivery? If yes, please explain: ______________________________

Birth Weight: ________ Age at which walked alone: __________ Age at which talked with 2 words together: __________

N.J.A.C.6A:162.2 & N.J.S.A. 18A:40-4 Each student upon entry into the school district, shall have a medical history & medical examination conducted at the medical home of the student, and a report sent to the school nurse. The school nurse will conduct height, weight, blood pressure, vision, and hearing screenings as per NJ schedule. Scoliosis screenings will be conducted in grades 4, 6, & 8 (ages 10-18).

I allow the school nurse to assess my child for scoliosis. _________ (Please place an X on one option)

I do not allow the school nurse to assess my child for scoliosis. _________

Parent Signature: ______________________________ Date: ______________