School Health Services
Ginette Bell, BSN, RN, CSN-NJ

HEALTH HISTORY

School Year _____

Student's Name _____ Birth Date _____ Gender _____

Address _____ Home phone _____

Physician's Name _____ Phone _____

List other children in your family. Please give birth date:

_____ _____

_____ _____

Dear Parent/Guardian:
We would like for your child to gain the most from his/her school experience. To accomplish this, it is necessary to have an updated health history every year. Please answer the following questions and return this form to the school nurse.

Allergies Yes ____ No ____ Type _____		Gastrointestinal	Yes ____ No ____
Reaction _____ Treatment/Medication _____		Headaches	Yes ____ No ____
Asthma Yes ____ No ____		Heart Disease/Murmur	Yes ____ No ____
Chicken Pox Yes ____ No ____ Date _____		Kidney/Bladder condition	Yes ____ No ____
Concussion/Head Injury Yes ____ No ____		Muscle/Bone Disorder	Yes ____ No ____
Diabetes Yes ____ No ____		Nutritional/Eating Problems	Yes ____ No ____
Ear Problems Yes ____ No ____ Specify _____		Speech Problems	Yes ____ No ____
Eye Problems Yes ____ No ____		Epilepsy/Seizures	Yes ____ No ____

Does he/she wear contact lenses? Yes ____ No ____

Does he/she wear glasses? Yes ____ No ____

Has your child started taking any medications on a regular basis? Yes ____ No ____
If yes, please explain: _____

Has your child recently been hospitalized or had any surgeries/operations? Yes ____ No ____
If yes, please explain: _____

Are there any recent changes in the home which might affect your child's learning? Yes ____ No ____
Please specify (divorce, illness, etc.) : _____

Is there anything more about your child's health that you think is important for us to know? Yes ____ No ____
Please explain: _____

In case of illness or injury and you cannot be reached, do we have your permission to take your child to the hospital? Yes ____ No ____ Hospital of choice: _____

I/we give permission for the school nurse to share this information with the principal, school social worker and teachers on a "need to know" basis. Please be assured that any information of a confidential nature will be treated with respect. Parent/Guardian Signature: _____

ROOSEVELT PUBLIC SCHOOL

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ *I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.*

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

School Health Services
Ginette Bell, BSN, RN, CSN-NJ
School Nurse

DENTAL FORM

Dear Parent/Guardian,

Healthy teeth and gums are an important part of a child's overall well being.

By encouraging healthy food choices with limited sweets, daily brushing and flossing, and regular dental examinations, dental problems can often be minimized or avoided.

Please ask your child's dentist to complete this form, then return it to the school nurse.

Student's Name _____

D.O.B. _____ Grade _____ Teacher _____

Please Check (for Dentist to complete):

___ The necessary dental service has been completed.

___ The student is receiving dental treatment for _____.

___ The student does not need dental treatment at this time.

Date of last dental exam _____

Dentist's Signature _____ Date _____

Office Stamp