

**HIGH BRIDGE PUBLIC SCHOOLS**  
**PRESCHOOL & KINDERGARTEN COMPREHENSIVE HEALTH HISTORY**  
*(To be completed by parent/guardian - have doctor review before exam)*

This very detailed history is an important permanent record, which follows your child throughout school. The information provided here may be useful in helping your child during their school years. Please complete both sides to the best of your ability. **If you feel uncomfortable with any question, just leave it blank. All information is kept confidential!**

CHILD'S NAME \_\_\_\_\_ SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 Parent/guardian name: \_\_\_\_\_ Phone number: \_\_\_\_\_  
 Address: \_\_\_\_\_

I. **Pregnancy/Infancy/Childhood: this child is number \_\_\_ of \_\_\_ children in family from oldest to youngest.**  
**Was this pregnancy high risk? Yes \_\_\_ No \_\_\_ If yes, why \_\_\_\_\_**

Mother's age during pregnancy \_\_\_\_\_ Under physician's care as of \_\_\_\_\_<sup>th</sup> month.  
 Drugs (including over-the-counter) taken during pregnancy: \_\_\_\_\_  
 Problems encountered during pregnancy or delivery (i.e., anemia, bleeding, high blood pressure, illness/injury): \_\_\_\_\_  
 Length of pregnancy: full term \_\_\_\_\_ # of weeks late \_\_\_\_\_ # of weeks early \_\_\_\_\_.  
 Birth: Vaginal \_\_\_\_\_ C-Section \_\_\_\_\_ Forceps Used \_\_\_\_\_ Drugs used during labor/delivery \_\_\_\_\_  
 \_\_\_\_\_ Anesthesia: Local \_\_\_\_\_ General \_\_\_\_\_ Spinal \_\_\_\_\_ None \_\_\_\_\_ Other \_\_\_\_\_  
 Birth Weight: \_\_\_\_\_ lbs., \_\_\_\_\_ oz. Apgar Score (if known) \_\_\_\_\_  
 Difficulty breathing at birth? \_\_\_\_\_ Oxygen used? \_\_\_\_\_ Birth defects: \_\_\_\_\_ Explain: \_\_\_\_\_

Jaundice developed the first week? \_\_\_\_\_ Started on \_\_\_\_\_ day after birth  
 Describe child as infant: \_\_\_\_\_  
 Developmental milestones: Recalled delays (any area): \_\_\_\_\_  
 Sat at \_\_\_\_\_ months; stood at \_\_\_\_\_ months; walked at \_\_\_\_\_ months;  
 Problems with speech development? \_\_\_\_\_ Explain: \_\_\_\_\_  
 Toilet trained at \_\_\_\_\_ months for one or both (wetting/soiling)  
 Plays with other children? \_\_\_\_\_ comments: \_\_\_\_\_  
 Now outgoing \_\_\_\_\_; shy \_\_\_\_\_; comments: \_\_\_\_\_  
 Made regular gains in height/weight \_\_\_\_\_; if no, explain \_\_\_\_\_  
 Serious injury/hospitalized? \_\_\_\_\_; explain (include date) \_\_\_\_\_

<u>History</u>	<u>Year</u>		<u>Year</u>
Hepatitis	_____	Asthma	_____
Neuromuscular Disease	_____	Chickenpox	_____
Convulsive Disorder	_____	Diabetes	_____
Heart Disease	_____	Middle Ear Infection	_____
Strep Infection	_____	Rheumatic Fever	_____
Mononucleosis	_____	Concussion	_____
Other: (please explain) _____			

**II. Current Health Patterns:**

**Food Allergy:** \_\_\_\_\_ **Explain:** \_\_\_\_\_  
Food sensitivities: \_\_\_\_\_ **Explain:** \_\_\_\_\_  
Eats wide variety of foods daily? \_\_\_\_\_ Regular meal schedule? \_\_\_\_\_ Describe appetite: \_\_\_\_\_  
Taking dietary supplements (e.g., vitamins, fluoride)? \_\_\_\_\_ What \_\_\_\_\_  
Unusual weight gain or loss at any time? \_\_\_\_\_ **Explain:** \_\_\_\_\_  
Food likes: \_\_\_\_\_ Food dislikes: \_\_\_\_\_  
*(consider 4 groups: milk products, fruits/vegetables, meat/poultry, fish, and grains)*  
Usual bedtime: \_\_\_\_\_ p.m. Usually rising time: \_\_\_\_\_ a.m. Sleeps soundly without interruption? \_\_\_\_\_  
**Explain:** \_\_\_\_\_  
Is child physically active daily? \_\_\_\_\_ **Explain:** \_\_\_\_\_  
Receives regular check ups with doctor? \_\_\_\_\_ **Comments:** \_\_\_\_\_

**III. Current Health Problems: Explain:**

If so, under ongoing care? \_\_\_\_\_ **Physician:** \_\_\_\_\_  
Allergies other than food (bee stings, etc.)? \_\_\_\_\_  
Drugs taken regularly in the past (include dates): \_\_\_\_\_  
Ear tubes? \_\_\_\_\_ right \_\_\_\_\_ left \_\_\_\_\_ **Date inserted:** \_\_\_\_\_ **Date removed:** \_\_\_\_\_  
Eyeglasses? \_\_\_\_\_ **Why?** \_\_\_\_\_ **When to be worn?** \_\_\_\_\_  
Emotional or Behavioral Issues: \_\_\_\_\_

**Medication taken regularly:**

Medication	Dosage	Reason

Will this medication be needed during school hours? No \_\_\_\_\_ Yes \_\_\_\_\_ **If yes, a doctor's order must be submitted along with the medication directly to the School Nurse on the first day of school.**

**Emergency medications required:** (A doctor's order must be submitted along with the medication directly to the School Nurse on the first day of school-forms are available on the website)

Inhaler \_\_\_\_\_ Epi Pen \_\_\_\_\_ Glucagon (for diabetics) \_\_\_\_\_ Other \_\_\_\_\_

**\*Throughout the year Service Dogs will be in our schools. Does your child have issues/concerns with dogs?**

NO \_\_\_\_\_ YES \_\_\_\_\_ **If yes, explain:** \_\_\_\_\_

**IV. Family Health History (pertains to child's natural siblings, parents, aunts, uncles, grandparents):**

Heart Disease \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Learning Problems \_\_\_\_\_  
Anemia \_\_\_\_\_  
Asthma \_\_\_\_\_  
Allergies \_\_\_\_\_  
Ulcers/Colitis \_\_\_\_\_  
Glandular Problems (pituitary, thyroid, etc.) \_\_\_\_\_  
Emotional Problems \_\_\_\_\_  
Seizures \_\_\_\_\_  
*(Note: mention relationship and age when started)*

V. **Dental History:**

**Special Dental Problems:** \_\_\_\_\_  
Name of Family Dentist \_\_\_\_\_  
Address \_\_\_\_\_  
Latest examination date: \_\_\_\_\_

VI. **Special Needs/Condition(s) requiring special school management (review with physician-Dr.'s order may be required) :**

Explain: \_\_\_\_\_  
\_\_\_\_\_

VII. **General Information:**

**Health Care Provider Information**

Family Physician/Pediatrician:		Phone Number:
Address:		

Does your child have health insurance? No \_\_\_\_\_ Yes \_\_\_\_\_

If **YES**, name of insurance company \_\_\_\_\_

if **NO**, NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit [www.njfamilycare.org](http://www.njfamilycare.org) to apply online.

You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

**Permission for care:** In the event of accident or illness, my child's school nurse has my permission to contact the physician(s) listed above regarding their care.

I give my permission

I do not give my permission

I understand that my child will be taken to the nearest Hospital in case of an emergency. I will be contacted when this is needed.

\*The Health Information contained herein **may** **may NOT** be shared with appropriate school personnel, as needed. (Nurses only share important information with staff on a need-to-know basis in order to maintain the safety and well being of the student.)

Signature of Parent/Guardian \_\_\_\_\_ Printed Name: \_\_\_\_\_

Date \_\_\_\_\_