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_____th 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)____
____

History	***Year***		***Year***
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 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______________________