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 _____ EpiPen _____ 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:_____
_____

Is your child independent in the bathroom YES NO

If NO your child needs in the bathroom help with: _____

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_____