CHESTERFIELD TOWNSHIP ELEMENTARY SCHOOL
HEALTH HISTORY QUESTIONNAIRE

NAME _____ DATE OF BIRTH _____
SCHOOL YEAR _____ TEACHER _____

Please answer the following questions about the student's medical history by circling the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions. (per NJAC 6A 16 1.4-8)

1. Is your child taking any medications? Yes No

MEDICATION NAME	DOSAGE	FREQUENCY

2. Has your child ever had or currently have:
a. restriction from physical education for a health related problem? Yes No
b. an injury or illness since the last questionnaire? Yes No
c. a chronic or ongoing illness (such as diabetes or asthma)? Yes No
(1) Does your child need an inhaler or nebulizer medication for school? Yes No
d. surgery, hospitalization or any emergency department visits? Yes No
e. any allergies to food, medication or latex? Yes No
(1) Does your child need an Epi-Pen and/or antihistamine (e.g. Benadryl) for school? Yes No
f. been stung by a bee? Any reaction? Yes No
g. any anemia, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Yes No
h. any bathroom issues? (frequency, bathroom accidents, kidney problems, bedwetting) Yes No
i. any concerns/history of developmental or behavioral issues (ADHD/Autism)? Yes No
Explain all "yes" answers here (include relevant dates) _____
_____
_____

3. Has your child ever had or does your child currently have any of the following ***head related conditions***
a. concussion , head injury or knocked out? Yes No
b. seizures? Yes No
c. frequent or severe headaches? Yes No
Explain all "yes" answers here (include relevant dates) _____
_____
_____

4. Has your child ever had or does your child have any of the following ***heart related conditions***:
a. restriction from sports for heart problems? Yes No
b. heart murmur? Yes No
c. high blood pressure? Elevated Cholesterol? Yes No
d. heart infection? Yes No
e. dizziness or passing out during or after exercise without known cause? Yes No
f. has provider ever ordered a heart test (EKG, echocardiogram, stress test, Halter monitor)? Yes No
g. racing or skipped heartbeat? Yes No
Explain all "yes" answers here (include relevant dates) _____
_____
_____

5. Has your child ever had or does your child have any of the following ***eye, ear, nose, mouth or throat conditions***:
a. vision problems: Wears eyeglasses, contacts, or protective eyewear? **(circle which type)** Yes No
b. hearing problems? Yes No

(1) wears hearing aides or implants? Yes No
c. nasal fractures or frequent nose bleeds? Yes No
d. wear braces, retainer or protective mouth gear? Yes No
e. frequent strep or any other conditions of the throat? Yes No
f. tubes in ears, tonsils and/or adenoids removed? Yes No

Explain all "yes" answers here (include relevant dates) _____

_____

_____

6. Has your child ever had or does your child have, any of the following ***neuromuscular/orthopedic conditions***:

a. a sprain or strain? Yes No
b. dislocated joint? fracture, stress fracture or broken bone? Yes No
c. wear a protective brace or equipment? Yes No

Explain all "yes" answers here (include relevant dates) _____

_____

_____

7. Has your child ever had or does your child have, any of the following ***general or exercise related conditions***:

a. difficulty breathing
(1) during exercise? After running 1 mile (if applicable)? Yes No
(2) coughing, wheezing or shortness of breath in weather changes? Yes No
(3) exercise induced asthma Yes No
b. viral infections (e.g. mono, hepatitis, Chicken pox)? Yes No
c. any of the following skin conditions: eczema, cold sores/ herpes, impetigo, MRSA, ringworm, warts? Yes No
d. heat related problems? (dehydration, dizziness, fatigue, headaches) Yes No
e. any emotional concerns? Yes No
f. absence or loss of an organ? (kidney, eyeball, spleen, testicle, ovary) Yes No

Explain all "yes" answers here (include relevant dates) _____

_____

8. Do you have any concerns regarding your child's weight? _____

9. Females only: Menstruation Yes No Any related issues? _____

10. Has your child received any immunizations in the past year? If yes, please attach a copy of the immunization record.

11. Last medical check up: Date _____ Physician: _____

NOTE: Scoliosis (lateral curvature of the spine) screening will be conducted by the school nurse on children in 5th and 6th grade.

YES My child can be examined **NO My family physician will perform an examination**

Should you have any questions, please call the school nurse.

I understand that relevant information regarding my child's health may be shared with appropriate school personnel and other health care providers as necessary.

I understand that the school nurse may provide first aid and emergency treatment including, but not limited to the administration of epinephrine.

_____ _____ _____

Signature of parent/guardian Date Telephone number

(2/2013)