Chesterfield Elementary School
30 Saddle Way, Chesterfield NJ • Main Office 609.298.6900

Home of the Chesterfield Dragons *Come grow with us!*

HEALTH HISTORY QUESTIONNAIRE

STUDENT NAME ___________________________________DATE OF BIRTH _______________GRADE/TEACHER ______________________

Please answer the following questions about the student's medical history. 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 medication(s)? (home and/or at school) YES NO

MEDICATION NAME	DOSAGE	FREQUENCY

2. Has your child ever had or currently have:

Restriction from physical education for a health-related problem?	YES	NO
An injury or illness since the last questionnaire?	YES	NO
A chronic or ongoing illness (such as diabetes or asthma)?	YES	NO
Does your child need an inhaler or nebulizer medication for school?	YES	NO
Surgery, hospitalization or any emergency department visits?	YES	NO
Any allergies to food, medication or latex?	YES	NO
Does your child need an Epi-Pen and/or antihistamine (e.g. Benadryl) for school?	YES	NO
Been stung by a bee? Any reaction?	YES	NO
Any dog allergy?	YES	NO
Any anemia, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders?	YES	NO
Any bathroom issues? (frequency, bathroom accidents, kidney problems, bedwetting)	YES	NO
Any concerns/history of developmental or behavioral issues (ADHD/Autism)?	YES	NO

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

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3. Has your child ever had or does your child currently have any of the following *head related conditions*:

Concussion, head injury or knocked out?	YES	NO
Seizures?	YES	NO
Frequent or severe headaches?	YES	NO

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

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4. Has your child ever had or does your child have any of the following *heart related conditions*:

Restriction from sports for heart problems?	YES	NO
Heart murmur?	YES	NO
High blood pressure? Elevated Cholesterol?	YES	NO
Heart infection?	YES	NO
Dizziness or passing out during or after exercise without known cause?	YES	NO
Has provider ever ordered a heart test (EKG, echocardiogram, stress test, Halter monitor)?	YES	NO
Racing or skipped heartbeat?	YES	NO

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

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5. Has your child ever had or does your child have any of the following *eye, ear, nose, mouth or throat conditions*:

Vision problems:	YES	NO
Wears eyeglasses, contacts, or protective eyewear? **(circle which type)**	YES	NO
Hearing problems?	YES	NO
Wears hearing aides or implants?	YES	NO
Nasal fractures or frequent nose bleeds?	YES	NO
Wear braces, retainer or protective mouth gear?	YES	NO
Frequent strep or any other conditions of the throat?	YES	NO
Tubes in ears, tonsils and/or adenoids removed?	YES	NO

STUDENT NAME: ________________________

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

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

A sprain or strain?	YES	NO
Dislocated joint, fracture, stress fracture or broken bone?	YES	NO
Wear a protective brace or equipment?	YES	NO

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

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

Difficulty breathing during exercise, or after running 1 mile (if applicable)?	YES	NO
Coughing, wheezing or shortness of breath in weather changes?	YES	NO
Exercise induced asthma	YES	NO
Viral infections (e.g. mono, hepatitis, Chicken pox)?	YES	NO
Any of the following skin conditions: eczema, cold sores/ herpes, impetigo, MRSA, ringworm, warts?	YES	NO
Heat related problems? (dehydration, dizziness, fatigue, headaches)	YES	NO
Any emotional concerns?	YES	NO
Absence or loss of an organ? (kidney, eyeball, spleen, testicle, ovary)	YES	NO

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

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8. Do you have any concerns regarding your child's weight? **YES NO**

9. Females only: Menstruation **YES NO**

Any related issues? **YES NO**

10. Has your child received any immunizations in the past year? **YES NO**

If yes, please attach a copy of the immunization record.

11. Last medical check up: Date ________________________ Physician: ___________________________

NOTE: Yearly screenings are conducted for all students. This may include vision, hearing, blood pressure and measurement of height and weight. Scoliosis (lateral curvature of the spine) screening will be conducted by the school nurse on children 10 years of age or older. Should you have any questions, please call the school nurse.

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

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.

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Signature of parent/guardian Date Telephone number