RIDGEWOOD PUBLIC SCHOOLS
Health Services
Ridgewood, New Jersey

School Health History Entrance Form

Please complete the following and return to the school nurse as soon as possible.

Child's Name_____ Sex M ☐ F ☐ Birth Date _____
(Last) (First)

Grade_____ School _____ Home Address _____

Father's Name _____ Mother's Name_____

Home Phone _____ Work Phone Mother _____ Father_____
Cell Phone: _____ Cell Phone _____

Siblings, Names/Ages_____

Language(s) spoken at home (other than English)_____

II. BIRTH & DEVELOPMENTAL HISTORY

Birth Weight: Pounds _____ ounces

Gestation (Duration of Pregnancy) _____ weeks or _____ months

Pregnancy: Illness of Mother Yes☐ No ☐ If yes, explain: _____

_____

Other areas of concern -- Yes☐ No ☐ If yes, explain: _____

Problems/labor & deliver-- Yes☐ No ☐ If yes, explain: _____

Growth and Development: Age child –

Sat alone _____ Crawled _____ Walked _____ First Spoke _____ Spoke in sentences _____

Coordination (difficulty) Yes☐ No ☐ If yes, explain: _____
(fine motor, large muscle, other areas of concern)

II. FAMILY MEDICAL HISTORY (Please specify: Allergies, Respiratory, Heart, Diabetes, Cancer, Other)

Father_____ Mother _____

Siblings_____ Relative_____

III. HEALTH HISTORY (Please check appropriate column, note year, and explain where applicable.)

Allergy Types	Reaction	School Restriction
Bee/Insect		
Drugs		
Food		
Pollen		
Skin		
Other (i.e. latex)		

Other Conditions	No	Yes	Year(s)	Explain
Asthma/Reactive Airway Passage				
Blood Disorder				
Cancer				
Concussion/Head Trauma				
Diabetes				
Digestive/Feeding Disorder				
Diseases, i.e. chicken pox				
Mononucleosis				
Mumps				
Measles				
Dietary Restrictions				
Emotional Problems				
Genitourinary Problems				
Hearing Difficulty				
Heart Disease (defects)				
Hospitalization(s)				
Severe Infections				
Kidney Disease				
Neuro-muscular Disorders or prosthesis				
Organs missing or impaired function of paired organs; i.e. kidneys, testes, eyes				
Orthopedic Disorder				

Other Conditions	No	Yes	Year(s)	Explain
Central Nervous System Disorder				
Rubella				
Skin Disorder				
Speech Impairment				
Surgical Procedure(s)				
Vision Problems				
Glasses/Contacts				
Other (list and explain) serious illnesses, accident, genetic disorders)				

A. Is the student receiving medication? Yes☐ No ☐ If yes, complete the following:

Medication(s)	Dose	Times	Reason	Date Prescribed	Prescribing Physician

B. Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

Yes☐ No ☐ If yes, explain: _____

_____

_____

C. Does the student require an special procedures and/or treatments?

Yes☐ No ☐ If yes, explain: _____

_____

_____

D. Is the student current under treatment for any health conditions?

Yes☐ No ☐ If yes, complete the following:

Condition **Physician** **Treatment**

_____

_____

_____

E. Has the student had a vision screening?

Yes☐ No ☐ If yes, please report results:
_____ (date) _____

F. Has the student had a hearing screening?

Yes☐ No ☐ If yes, please report results:
_____ (date) _____

G. Has the student had any special medical examinations?

Yes☐ No ☐ If yes, complete the following: (i.e., ophthalmologic, neurological, orthopedic, etc.):

Specialty	Physician	Exam Date	Diagnosis	Recommendation

H. Has the student had any experience(s) which you feel may affect his/her physical, mental, and/or social development?

Yes☐ No ☐ If yes, please explain:

_____

_____

_____

_____

I. Please complete: Last medical examination:

Date:	**Reason**
Physician:	**Findings**
Address:	
Phone#:	

Relevant health information may be shared with school personnel who have direct responsibility for the care of the student. Please contact the school nurse to arrange a conference to discuss any medical conditions(s) or special healthcare needs.

Parent Signature **Date**

12/06

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