

NEW STUDENT HEALTH SURVEY

(TO BE COMPLETED BY THE PARENTS)

Student Name _____ Date of Birth _____

Parent Name _____ Today's Date _____

Address _____ Phone _____

Family Physician _____ Phone _____

Circle Assigned School: AWR SB NPMS NPHS

Your child's health history will help us assess any conditions that may require adjusting his/her school program. The information that you record on this form will become a part of your child's school health record.

Speech and/or Hearing Difficulties _____ Yes _____ No

Specify type and treatment. _____

Vision Difficulties _____ Yes _____ No

Specify type and treatment. _____

Any Condition Currently Being Treated by a Physician _____ Yes _____ No

Specify type and treatment. _____

Food Allergies _____ Yes _____ No

Specify foods and treatment. _____

Is this a possible life-threatening allergy? _____ Yes _____ No

Other Allergies _____ Yes _____ No

Specify kind and treatment. _____

Is this a possible life-threatening allergy? _____ Yes _____ No

(OVER)

NEW PROVIDENCE BOARD OF EDUCATION
356 ELKWOOD AVENUE
NEW PROVIDENCE, NEW JERSEY 07974

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Previous Surgery or Hospitalizations _____ Yes _____ No

Specify date and reason. _____

Does Your Child Routinely Take Any Medication? _____ Yes _____ No

Specify medication, dosage, and frequency. _____

Reason: _____

Will this medication be taken during school hours? _____ Yes _____ No

(Please note that all medication administered at school must be brought to the Health Office with a written physician's note.)

Please Share Any Health Concerns About Your Child.

HEALTH HISTORY: Please indicate any of the following conditions your child has experienced.

	<u>Year</u>		<u>Year</u>		<u>Year</u>
Asthma	_____	Measles	_____	Rubella	_____
Chicken Pox	_____	Migraines	_____	Scarlet Fever	_____
Diabetes	_____	Mono	_____	Scoliosis	_____
Heart Disease	_____	Mumps	_____	Seizures	_____
Hepatitis	_____	Ear Infections	_____	Strep Infections	_____
Lyme Disease	_____	Pneumonia	_____	Tuberculosis	_____
Other	_____	Rheumatic fever	_____	Whooping Cough	_____

RETURN THIS FORM TO SCHOOL