ROXBURY TOWNSHIP PUBLIC SCHOOLS

ELEMENTARY SCHOOL HEALTH HISTORY

Child's Name _____ Sex ____ Birth Date _____
Physician _____ Phone _____
Dentist _____ Phone _____

Birth/Growth History

Birth weight _____ Length_____ Breathing Problems _____
Gestation/Prematurity _____ Hand Preference _____
Complications of Delivery _____ Age Toilet Trained _____
Birth Defects _____ Other Concerns _____

Has your child ever had any of the following?

Yes	No	Condition		Yes	No	Condition
		Lyme Disease				Anemia
		Hepatitis				Bladder/Kidney Infections
		Neuromuscular Disorder				Bronchitis/Chronic Cough
		Asthma				Concussion
		Chickenpox (list date)				Eye Problems
		Convulsive Disorder				Frequent: Colds/Sore Throats
		Diabetes				Headaches
		Encephalitis				Nosebleeds
		Heart Disease				Stomach Aches
		Meningitis				Hearing Loss (under care?)
		Mononucleosis				Hernia
		Otitis Media (ear infection)				High Fever (over 104)
		Pneumonia				Leg/Joint Pain
		Rheumatic Fever				Skin Problems
		Strep Infections				Scarlet Fever
		Tonsillitis				Wears Glasses
		Tuberculosis				Speech Concerns
		Dental Concerns				Psychological Evaluation

Please explain any "YES" responses below:

_____
_____
_____
_____
_____

**********ADDITIONAL INFORMATION REQUIRED ON BACK**********

HEALTH HISTORY AND OTHER INFORMATION

Has your child ever had an allergic reaction to:

Foods: _____ Medicine: _____

Bees: _____ Immunizations: _____

Other: _____ Please Explain: _____

_____

_____

Is your child taking any medication at home or during school hours? ____ If yes please indicate the reason/ medication name/dosage/frequency: _____

_____

_____

Has your child had any:

Serious Illness/Serious Injury/Broken Bones (Date and Explanation): _____

_____

_____

Hospitalizations/Operations (Date and Explanation): _____

_____

_____

Dizzy Spells/Fainting/Blackouts/Unconsciousness (Date and Explanation): _____

_____

_____

Do you believe your child would be able to take regular Physical Education: _____

If not, why? _____

_____

Is there any further health information that might affect your child's education? _____

_____

Please use this space for any other comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date_____ Parent/Guardian Signature: _____

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: | Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:

Weight *(must be taken within 30 days for WIC)*	
Height *(must be taken within 30 days for WIC)*	
Head Circumference *(if <2 Years)*	
Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS ☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)
Signature/Date

NAME:

ROXBURY TOWNSHIP PUBLIC SCHOOLS – STREP PERMISSION FORM

Dear Parent or Guardian,

Rheumatic Fever is one of the most important causes of heart disease in children and adolescents. It is a preventable disease. Strep infections of the throat can cause attacks of Rheumatic Fever. However, to prevent this disease, we must first find the strep germs which are commonly found in the nose and throat. A throat culture is the only reliable way to diagnose a strep infection.

Your child can have a throat culture without charge in the school nurse's office, if he or she shows signs of a nose or throat infection.

To help protect your child's heart, please sign the following permission form. This form will remain in effect as long as the student is enrolled in the Roxbury Township School System.

The school nurse has my permission to obtain a throat culture on my child.

_____ ____ / ____ / ____
Student's Name Birth Date

_____ ____ / ____ / ____
Parent/Guardian Signature Date

Student's Name: _____

Address: _____
(Street) (Town) (Zip)

School: _____ Grade: _____

Birth Date: ____ / ____ / ____ Home Phone #: _____

FOR NURSE'S USE ONLY! Please do not write below this line.

GRADE	DATE	10 MIN.	Rx or COMMENTS