ROXBURY TOWNSHIP PUBLIC SCHOOLS

STUDENT HEALTH HISTORY

Child's name_____Gender_____Birth date _____

Physician_____Phone number_____

Has your child seen a dentist? ____Yes ____ No Dental concerns_____

Has your child seen an eye doctor?____Yes _____ No Wearing glasses?____

Has your child ever had any of the following?

Yes	No	Condition	Yes	No	Condition
		Anemia			Asthma
		Bladder/Kidney issues			Bronchitis
		Chicken pox (date:_____)			Concussion (date:_____)
		Convulsions/Seizure disorder			Diabetes
		Encephalitis			Eye problems
		Fever over 104 degrees			Headaches/migraines
		Hearing loss			Heart disease
		Hepatitis			Hernia
		Leg/joint pain			Lyme disease (date:_____)
		Meningitis			Mononucleosis
		Neuromuscular disorder			Nosebleeds
		Otitis media (ear infections)			Pneumonia
		Psychological evaluation			Rheumatic fever
		Scarlet fever			Skin problems
		Speech concerns			Stomach aches
		Strep throat			Surgery (date:_____)
		Tonsillitis			Tuberculosis

Please complete back side

Please explain any “YES” responses from the first page:

_____
_____
_____
_____
_____
_____

Has your child had any reaction to:

Foods: _____ Medicine: _____
Bee/insect stings: _____Immunizations:_____
Other:_____ Please explain:_____

Is your child currently taking any medication at home?: _____
Will your child need medication during the school day?:_____
What is the reason for the medication? _____

Does your child have any health concerns or congenital disorders that you feel may affect your child's learning?_____
_____
_____

Are there any health concerns or physical restrictions that you feel may affect your child’s ability to participate in physical education? **If so, please provide further documentation from the treating physician.** _____
_____
_____

Is there any other health concern that you would like to share with us?_____
_____
_____

Date:_____ Parent/Guardian signature:_____