HEALTH HISTORY QUESTIONNAIRE
School Year 20 - 20

STUDENT NAME _____ DATE OF BIRTH _____ GRADE _____

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) _____

_____

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) _____

_____

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) _____

_____

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

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

STUDENT NAME: _____

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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) _____

_____

6. 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) _____

_____

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

8. Females only: Menstruation ▢**YES** ▢**NO**
Any related issues? ▢**YES** ▢**NO**

9. Has your child received any immunizations in the past year? ▢**YES** ▢**NO**
If yes, please attach a copy of the immunization record.

10. 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 for scoliosis** ▢**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.

_____ _____ _____
Signature of parent/guardian Date Telephone number