Allamuchy Township School District Registration

New Student Health History

(To be completed by parent/guardian)

Thank you for taking the time to complete this comprehensive health history. The information provided Is confidential, and It will only be used by the school nurse and other school personnel you designate to ensure the health and safety of your child.

Name of person completing this form _____

Student Data Today's Date _____

Name:_____

Birth Date: _____

Address

Street:_____

City: _____ State: _____ Zip: _____

Phone Number: _____

Place of Birth (City/State) _____

Family Data

Student Lives with:

Name Relationship

_____

_____

_____

_____

_____

_____

_____

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Family Health History

	Name	Age	Occupation	Level of Education
Mother				
Father				
Stepmother				
Stepfather				
Siblings				

General Health of Family Members

Mother _____

Father _____

Stepmother _____

Stepfather _____

Siblings _____

Describe any family health concerns the school nurse should be aware of (hereditary illness, chronically ill family members, contagious diseases in home, etc.)

_____

_____

Describe any economic concerns the nurse should be aware of (financial problems, poor housing, lack of clothing, problems affording medical or dental care, etc.)

_____

_____

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Student Health Data

Please check and date all items that apply to the student's current health status, past and present.

☐	Normal Pregnancy	_____	☐	Serious Injury	_____
☐	Problem Pregnancy	_____	☐	Headaches	_____
☐	Vaginal Delivery	_____	☐	Seizures	_____
☐	Caesarian Delivery	_____	☐	Concussion/Head Injuries	_____
☐	Prematurity	_____	☐	Eyes (glasses/contacts)	_____
☐	Hospitalization	_____	☐	"Lazy Eye"	_____
☐	Surgery	_____	☐	Ears (infections, etc.)	_____
☐	Accidents	_____	☐	Tubes in ears	_____
☐	Broken Bones	_____	☐	Difficulty Hearing/Aids	_____
☐	German Measles/Rubella	_____	☐	Chicken Pox	_____
☐	Skin (rashes, eczema, etc.)	_____	☐	Impetigo	_____
☐	Head Lice	_____	☐	Hepatitis	_____
☐	Mononucleosis	_____	☐	Frequent Colds	_____
☐	Strep Throat	_____	☐	Asthma/Breathing Problems	_____
☐	Heart Problems	_____	☐	Anemia	_____
☐	Heart Murmur	_____	☐	Constipation/Diarrhea	_____
☐	Bedwetting	_____	☐	Daytime wetting/soiling	_____
☐	Frequent Stomach Aches	_____	☐	Excessive weight gain/loss	_____
☐	Pinworms/Parasites	_____	☐	Urinary Problems	_____
☐	Excessive Thirst	_____	☐	Muscle Problems	_____
☐	Diabetes	_____	☐	Mumps/Measles	_____
☐	Hernia	_____	☐	Thyroid/Hormone Problems	_____
☐	Neurological Problems	_____	☐	Scoliosis/Spine Problems	_____
☐	Immune Disorder	_____	☐	Lyme Disease	_____

If needed, use this space to further describe any of the critical items.

_____

_____

_____

Allergies

List any allergies the student has to medications, plants, insects, food, etc. Note if the allergy is severe or life threatening and describe the prescribed treatment for the allergic reaction.

_____

_____

_____

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List all medications the student takes on a regular basis, both prescription and over the counter. Please include the dosage, time and reason for the medication.

_____
_____
_____

Please express any concerns you may have about the development, behavior or emotional heath of this student.

_____
_____
_____

Please describe any limitations or restriction on the student's activities during the school day.

_____
_____
_____

Student's Primary Cary Physician _____

Student's Special Care Physician _____

Health Insurance Carrier _____

Policy and ID Numbers _____

Dental Health

Name of Dentist _____

Does the student receive regular dental check-ups? _____

When was the last dental exam? _____

Detail any problems with teeth or gums _____

Please do not hesitate to contact me with any questions or concerns you may have about your child or the school health services program. (908) 852-1894 x303

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MANDATORY HEALTH CARE DOCUMENT TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

Name	_____	Date of Birth	_____
Height	_____	Blood Pressure	_____
Weight	_____	Respiration	_____
Vision	_____	Hearing	_____

Allergies _____

Medications _____

System	OK	Problem Found	If problem found, note action taken
General/Nutrition	☐	☐	_____
Skin/Hair/Nails	☐	☐	_____
Eyes/Ears	☐	☐	_____
Nose/Throat	☐	☐	_____
Teeth/Gums	☐	☐	_____
Lymphatic/Thyroid	☐	☐	_____
Chest/Breasts	☐	☐	_____
Respiratory	☐	☐	_____
Cardiac	☐	☐	_____
Gastrointestinal	☐	☐	_____
Urinary/Genital/Hernia	☐	☐	_____
Musculoskeletal/Spine	☐	☐	_____
Neurologic	☐	☐	_____
Emotional/Behavioral	☐	☐	_____

Recommendations _____

_____

Activity Restrictions _____

_____

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IMMUNIZATIONS/TEST

Lead Level	_____					
DPT/DT/Tetanus DTAP/DPT Acell	_____	_____	_____	_____	_____	_____
	(Letter required from MD if exempt from pertussis vaccine. Scan and Attach)					
Polio	_____	_____	_____	_____	_____	_____
Measles/Mumps/ Rubella/MMR	_____	_____	_____			
Hepatitis B	_____	_____	_____			
Hib	_____	_____	_____	_____		
Varicella	_____	_____				
Mantoux	_____	RESULT	_____			
Tine	_____	RESULT	_____			
Influenza	_____	_____				
Pneumococcal	_____	_____	_____	_____		

Physician Name (Please Print) _____

Physician Signature or Stamp _____

Date of Exam _____

Date this form was completed _____

Please email completed forms along with required documents to Pat Gardiner:
pgardiner@aes.k12.nj.us
Or mail to:
Allamuchy Township School
1686 County Rt 517
Allamuchy NJ, 07820
Attn: Pat Gardiner
You may also call the office to set up an appointment to drop off your paperwork: 908 852 1894 x300