SOUTHAMPTON TOWNSHIP PUBLIC SCHOOLS

in Historic Vincentown Village
Southampton, New Jersey 08088

"Building a Tradition of Excellence"

Christine Palmer, MSN, RN, CSN School #1 Nurse (609) 859-2256 ext. 142 FAX (609) 859-0142

CONFIDENTIAL HEALTH HISTORY

Child's Name _____ Gender: ❒ M ❒ F Date of Birth _____

Parents'/Guardians' Names _____ Phone # _____

Address _____

Physician/Nurse Practitioner _____ Phone # _____

Dentist _____ Phone # _____

I. Perinatal and Developmental History

Did the mother have any problems/illness during the pregnancy or the birth? ❒ Yes ❒ No

If yes, explain _____

Was your child born ❒ Full term ❒ Early ❒ Late Birth weight: _____

Did your child have any problems/illness while in the hospital? ❒ Yes ❒ No

If yes, explain_____

Please give the approximate age at which your child:

Crawled _____ Walked _____

Said single words _____ Toilet trained _____

Spoke in sentences _____ Dressed self _____

II. Family/Social

Are both parents in good health? ❒ Yes ❒ No

Do any family members have serious health problems that we should be aware of? ❒ Yes ❒ No

If yes, explain _____

Family Members: Please list all people living in household:

Name	Relationship to Student	Occupation or Grade/Age (if sibling)

III. Student Health Status

Does your child have Asthma?* ❒ Yes ❒ No If yes, medications taken: _____

Does your child have Allergies? ❒ Yes ❒ No If yes, please explain:_____

Epinephrine Pen prescribed?* ❒ Yes ❒ No

Does your child have Diabetes?* ❒ Yes ❒ No

Does your child have Seizures?* ❒ Yes ❒ No

If you answered yes to any of the above questions, you will need to fill out additional medical forms provided by the nurse.

Complete the following checklist by indicating any of the following conditions, past or present:

❒ ADD/ADHD	❒ Kidney disorder	❒ Sore throat, frequent
❒ Neurological disorder	❒ Urinary problems	❒ Frequent nosebleeds
❒ Head Injury/Concussion	❒ Stomachaches, frequent	❒ Ear tubes inserted
❒ Headaches, frequent	❒ Constipation/Diarrhea	❒ Hearing deficit
❒ Cancer/Leukemia	❒ Diet Restrictions	❒ Hearing aid or other device
❒ Heart problem/defect	❒ Orthopedic problems	❒ Vision deficit
❒ Cystic fibrosis	❒ Fractures	❒ Glasses/contacts
❒ Respiratory disorder	❒ Activity restrictions	❒ Speech concerns
❒ Eczema	❒ Physical disability	❒ Sleep problems
❒ Other _____		

Please explain any further details concerning the above checked areas if needed: _____

_____

List major injuries, operations and/or hospitalizations: _____

_____

IV. Medication

1. Does student take any medication (prescribed and/or over the counter)? ❒ Yes ❒ No

   If yes, please explain. Include dosage, reason and frequency: _____

   _____

2. Is medication required during school hours? ❒ Yes ❒ No

   If yes, please obtain necessary form from the nurse.

V. Summary

Do you have any other comments or concerns about your child's health, development, behavior, family or home life that you would like the school personnel to be aware of? If yes, please explain:

_____

_____

I understand that relevant information regarding my child's health may be shared with appropriate school personnel and other health providers as necessary.

I hereby state that to the best of my knowledge, my answers to the above questions are correct.

_____ _____

Parent/Guardian Signature *Date*