Rockaway Valley School
11 Valley Road
Boonton Township, NJ 07005

HEALTH HISTORY

Date______________________

Child's Name____
(Last) (First) (Middle)

Grade__________ Gender: M________F________ Birthdate________________

Street Address____

Home Phone #________________________ Emergency Phone #___________________________

Parents' Name(s): Father___________________________ Mother___________________________

This child is in the custody of [ ] both parents [ ] mother only [ ] father only

If divorced, who is the parent permanent resident (PPR)? (Legal documentation may be required.)

____

Legal Guardian (if other than parent) ____

1. Siblings:

Name	Age	Sex

2. Any special needs children in family? ____________________________

3. Do any relatives/others live in the home? List name and relationship.

____

____

4. Birth information:

Is your child adopted? ________________

Was your child born prematurely? __________________

What was your child's birth weight? _________________

Any difficulties experienced during pregnancy or delivery? ___________________

At what age did your child walk unassisted? ___________months

At what age did your child talk in phrases? ____________months

5. Check which of the following your child has had and note approximate date:

Chicken Pox__________ Fifth Disease_________ Strep/Scarlet Fever_________
Pneumonia __________ Mononucleosis_________ Lyme__________

6. Is your child currently under a doctor's care?____

If yes, explain____

7. Does your child have:

Allergies Yes_____ No_____ To what? _______________ Medication___________________
Asthma Yes_____ No_____ Triggers_______________ Medication___________________
Diabetes Yes_____ No_____ On insulin_______________Type/how often________________

Epilepsy or convulsions Yes______ No______ Drug Sensitivities Yes______ No_____
Heart condition Yes______ No______ Attention Deficit Disorder Yes______ No_____
Orthopedic problem Yes______ No______ Neuromuscular Disorder Yes______ No_____
Congenital defects Yes______No______

8. Has your child had:

Eczema Yes_____No_____ Hives Yes_____No_____
Fractures Yes_____No_____ Operations Yes_____No_____
Serious Injury Yes_____No_____ Serious Illness Yes_____No_____

Frequent:
Headaches Yes_____No_____ Nosebleeds Yes_____No_____
Ear infections Yes_____No_____ Sore throats Yes_____No_____
Abdominal Pain Yes_____No_____ Urination Yes_____No_____
Pain in legs Yes_____No_____

9. Does your child:

Have trouble doing close work Yes_____No_____
Seeing distant objects Yes_____No_____
Wear glasses Yes_____No_____
Wear contacts Yes_____No_____
Has trouble hearing Yes_____No_____
Wears a hearing aid Yes_____No_____
Has difficulty with speech Yes_____No_____

10. Takes medication daily Yes _____No_____ For what_________________________

Name/dose/frequency of medication____

____

11. Takes emergency medication Yes _____No_____ For what_____________________

Name/dose/frequency of medication ____

____

Does this medication need to be kept in school? Yes ______No______

PLEASE NOTE: STATE LAW REQUIRES THAT DOCTOR AND PARENT/GUARDIAN GIVE WRITTEN PERMISSION FOR MEDICATION TAKEN DURING SCHOOL HOURS.

12. Does your child have any problems which would prevent participation in regular Physical Education? Yes _____No_____

13. Has your child ever experienced a severe emotional shock? (auto accident, death of a family member or friend, family upset, etc.) If so, what, when:

____

____

____

14. If you have responded Yes to any of the above questions, please explain below:

____

____

____

15. Please note any problems or other matters which you would like to discuss with the school staff (administrator, nurse, psychologist, guidance counselor, teacher):

____

____

____

PLEASE NOTIFY THE SCHOOL NURSE OF ANY FURTHER IMMUNIZATIONS THAT YOUR CHILD MAY RECEIVE.

* *

Thank you for assisting us in getting to know more about your child.

Parent/Guardian Signature____

Date:__________________________ (Revised 1/14)