Hopatcong Borough Schools - Little Chiefs

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 had a vision exam___Yes ___No Results: _____

Has your child had a hearing exam ___Yes ___No: Results:_____

Has your child ever had any of the following?

Yes	No	Condition	Yes	No	Condition
		Anemia			Asthma
		Bladder/Kidney issues			Bronchitis
		Chickenpox (date:_____)			Concussion (date:_____)
		Convulsions/Seizure disorder			Diabetes
		Encephalitis			Eye problems
		Fever over 104 degrees			Headaches/migraines
		Hearing loss			Heart disease Cardiovascular problems
		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
		Sleep problems			Bee/wasp stings

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 dietary restrictions?_____

Does your child have any health concerns or congenital disorder 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:_____

Please fax this form to 973-398-9048 or email alandrud@hopatcongschools.org

3/2023