SOUTH BRUNSWICK TOWNSHIP PUBLIC SCHOOLS

HEALTH HISTORY Grades 6 -12
(*To be completed by parent/guardian*)

Family:

Child's name: _____ Date of Birth: _____

Mother's name: _____ Father's name: _____

Guardian's name: _____ Present marital status: _____

This child is # _____ of _____ children

Recent changes in family life: _____

Chronic diseases in family: _____

Medical History:

Frequent headaches: _____ Frequent ear infections: _____ Stomach complaints: _____

Chicken Pox: Yes_____ No_____ Date: _____ Speech difficulties: _____ Hearing difficulties: _____

Glasses: _____ Contacts: _____ Used to improve: Near Vision: _____ Far Vision: _____

Asthma: _____ (If your child has asthma, please see the school nurse.)

Uses Inhaler: _____ Name of Inhaler: _____ Uses Nebulizer: Yes_____ No_____

Allergies: _____ (If allergy exists, please see the school nurse.)

Medications for allergies: _____ Epi-pen prescribed?: Yes_____ No_____

Seizures: _____ Heart murmur: _____ Anemia or blood conditions: _____

Serious illness: _____ Head Injury: _____ Orthopedic conditions: _____

Recent surgery: _____ Hospitalizations: _____

Chronic health conditions: _____

Current Status:

Routine medication(s): _____

(If medications need to be taken during school hours, please see the school nurse.)

Current activity restriction(s): _____

Is there any other information that you think would be helpful for school personnel to be aware of to best assist your student at school?: _____

_____

_____

_____

_____

_____

SOUTH BRUNSWICK TOWNSHIP PUBLIC SCHOOLS

HEALTH QUESTIONNAIRE Grades 6-12
(To be completed by student)

Student's name: _____ Date of Birth: _____

The following is a list of conditions that sometimes offers young people concern. Check each one as to whether you are concerned by it often, occasionally, or never.

	Often	Occasionally	Never
Skin trouble (rashes or pimples)			
Headaches			
Vision problems			
Hearing problems			
Toothaches			
Stomach pains			
Loneliness			
Anger and/or temper			
Nervous or anxious			
Trouble sleeping or getting to sleep			
Tired all the time			

	Yes	No
Do you think you are a healthy person?		
Are you content with your weight and height?		
Are you content with your social life?		
Are you glad to come to school?		

List any information you want or would like the school to know about your health and well being: _____

_____

_____

_____

_____

_____

_____