South Brunswick School District
Student Health History

Student Name_____Date of Birth_____Gender_____
Address_____Phone_____
Parent/Guardian Name(s)_____
Birth Order: Child #_____ of _____
Problems during first year_____
Recent Changes in home life_____
Chronic Family Illness_____

Medical History:
Asthma or RAD? Yes No Uses Inhaler Yes No Uses Nebulizer Yes No
Allergies? Yes No If yes, to what_____ EpiPen Yes No
Vision Issues? Yes No Glasses Yes No Near or Far Contact Lenses Yes No
Hearing Difficulties? Yes No Use of hearing aid? Yes No
Speech Difficulties? Yes No Seen by speech therapist? Yes No
Chronic Health Conditions?_____
Surgery or Hospitalizations?_____

(Indicate age of occurence or onset)

Frequent stomach aches	_____	Seizures	_____	Heart Disease	_____
Frequent sore throats	_____	Anemia	_____	Broken bones	_____
Frequent headaches	_____	Sickle Cell	_____	Other	_____
Frequent ear infections	_____	Diabetes	_____		_____
Neuromuscular Disease	_____	Head Injury	_____		

Current Medical History:
Routine Medications?_____
Activity Restrictions? (May require MD note)_____
Sleeping Issues?_____

Social
Makes friends easily?_____
Temperament?_____

Is there any additional information that would help us better care for your child? _____
_____
_____

Signature Of Parent/Guardian_____ Date _____