PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

REGISTRATION HEALTH HISTORY

Student's Name:_____ **Date of Birth:**_____

School:_____ **Grade:**_____

IMMUNIZATION RECORD

Immunization Document Received Date _____

Requested from parents/guardian Date _____

CHILDHOOD ILLNESSES, INJURIES, OPERATIONS, ORTHOPEDIC CONDITIONS:
Please give age of child when illness, injury, occurred explain:

Asthma _____ Measles_____
Chicken Pox _____ Mononucleosis_____
Diabetes _____ Ear Infections_____
Heart Condition _____ Pneumonia/Bronchitis_____
Kidney/Bladder Condition _____ Rheumatic Fever_____
Strep Infection _____ Seizure(s) _____

Other

Any known speech/hearing problem: _____
Any known Visual Problem: _____
Allergies or Eczema: _____
Behavioral Difficulties: _____
Gastrointestinal Problem: _____
Toileting Difficulties: _____
Neurological Disorders: _____
Muscle or Bone Problems: _____
Other Medical Conditions: _____
Previous Injuries/Accident: _____
Sleeping Problems: _____
Significant or Frequent Illness: _____
Surgery: _____
Breathing Difficulties: _____
Nutritional/Eating Problems: _____
Other difficulties: _____

Has the child ever had prolonged use of medication, or is any medication or therapy being given at this time? If so, please explain:_____

_____

(over)

Physical Limitations:

_____

_____

Has your child ever been confined to a hospital? If so, please explain:

_____

_____

Has your child ever been advised not to participate in a sport or to reduce activity?
If so, please explain:

_____

_____

Has your child had a loss of, or serious impairment of a paired organ such as a kidney, eye, lung, etc. If so, please explain:

_____

_____

List additional health information.

_____

_____

I/we give permission for the nurse to share any health-related information with principal, guidance counselors & teachers on a "need to know" basis for as long as my child is a student in Edison Public Schools.

My child is covered by health insurance ___ yes ___ no

My child receives his/her health care at: _____
Name of health care provider or clinic

_____ _____
Signature of Parent/Guardian Date