Holmdel Township School District Nursing Department

Village School
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HEALTH HISTORY FORM

Student's Name:_____ Birthdate:_____ Sex:____
Address:_____ Telephone:_____

Doctor's Name:_____ Telephone:_____

New Students: Attach a copy of your child's immunization record along with a copy of their physical, within the last six months, signed by your doctor. This must be submitted at time of registration.
Returning Students: Attach a copy of your immunization record if you have had any new vaccine and/or new condition/illness since last school year.

Does your child have any ongoing or chronic illness? If yes, please describe:_____
_____

Does your child take any medications? If yes, please list:_____
_____

Does your child have any allergies or asthma? If yes, please describe:_____
_____

Please provide a new Food Allergy Action Plan or Asthma Action Plan with new medications each school year.

Does your child have a life threatening allergy that may require the administration of an Epinephrine auto-injector?_____

Does your child carry any medication(s) with him/her to school? If yes, please describe:_____
_____

If your child carries an Epinephrine auto-injector (such as EPIPEN) or a metered dose inhaler for asthma, please contact the school nurse as soon as possible to discuss the care of your child during the school year.

Does your child have any of the following:

Anxiety/Nervousness:_____ Frequent Headaches:_____
Bleeding issues:_____ Diabetes:_____
Frequent ear infections:_____ Seizures:_____
Frequent sore throats:_____ Gastrointestinal issues:_____

Are there any other health conditions or social issues the student is going through that we should be aware of? If yes, please describe:_____
_____

Parent signature:_____ Date:_____

Parent signature:_______________________________________ Date:_______________