

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: _____

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