Carlstadt Public School
550 Washington Street ◇ Carlstadt, NJ 07072
Phone: 201-672-3000

STUDENT HEALTH HISTORY

Dear Parents/Guardians:
In order to keep our student health records current, we are asking you to please complete the following health history for your child. It is very important that we have this information to better care for your child's health.

I give my permission to share this information with appropriate school staff. ____yes ____no

RUTH POLIFRONIO, R.N. - School Nurse

CHILD'S NAME _____Grade_____

Child's Date of Birth_____ Age_____ Gender _____**M** _____**F** (check one)

	If Yes, Please indicate Date	Treatment and/or restrictions recommended
ALLERGIES		
ASTHMA		
CHICKEN POX		
CONGENITAL PROBLEMS		
CONVULSIONS		
DIABETES		
HEART AILMENTS (SPECIFY)		
HOSPITAL STAYS (SPECIFY)		
RASH (SPECIFY)		
TENDENCY TO BLEED (SPECIFY)		
URINARY PROBLEMS		
OTHER (SPECIFY ANY PHYSICAL LIMITATIONS AND RESTRICTIONS)		

Is your child presently taking a prescription medication? Yes_____ NO_____

If yes, please indicate the name of medication, dosage, time of day given and reason for use.

Signature of Parent/Guardian_____Date _____