BRIDGEWATER-RARITAN REGIONAL SCHOOL DISTRICT
KINDERGARTEN & PRESCHOOL –STUDENT HEALTH HISTORY

PAST HEALTH RECORD: To be completed by parent

Date of last physical exam: _____

Child's Name _____ _____ _____
Last First Middle

Date and Place of Birth _____ _____ Sex_____

Parents' Names_____ _____
Parent/Guardian 1 Parent/Guardian 2

Address _____ _____ _____
Street City Zip

Phone Number _____

1. Age of Walking _____ 2. Age of Talking _____
3. Behavior (habits): (Write details in blank spaces)
   - Speech difficulties_____
   - Bed wetting_____
   - Disturbed sleep_____
   - Nail biting_____
   - Finger sucking_____
   - Persistent crying_____
   - Temper tantrums (type, frequency)_____
   - Poor eating habits_____
   - Adequate diet_____ Particular dislikes_____
   - Bowel habits_____
   - Mouth breathing_____
4. Description of General Behavior:
   _____
   _____
5. Approximate gain in last 12 months: Wt._____ Ht._____
6. Diseases (give approximate year):
   - Allergy_____
   - Asthma_____
   - Bronchitis_____
   - Chicken Pox_____
   - Convulsive Disorder_____
   - Diabetes_____
   - Eczema_____
   - Kidney or Bladder Problems_____
   - Lyme Disease_____
   - Otitis Media_____
   - Pneumonia_____
   - Rheumatic Fever_____
   - Scarlet Fever_____
7. Tuberculosis contacts: State who and when (If none, so state)
   _____
   _____
8. Operations/Injuries_____
9. Eye Symptoms_____ Wears glasses_____
10. Frequent sore throat_____ 11. Frequent earache _____ Hearing problem_____
12. Frequent colds_____ 13. Frequent headache_____ 14. Toothache_____
15. Stomach disorders_____
16. Pain: Joints_____ Muscular_____ Other_____
17. Heart Conditions/murmur_____
18. Hernia_____ Nosebleeds_____
19. Does child take any medication?_____
    Has your child been diagnosed with any medical condition?____ What_____

Parent gives permission for the school nurse to share medical information with school staff as necessary.

_____ _____
Signature of Parent/Guardian Date

Student's Name: _____ D.O.B._____ Grade: _____ Homeroom: _____

FOLLOWING INFORMATION TO BE COMPLETED BY PHYSICIAN OR MEDICAL PROVIDER

IMMUNIZATIONS: PLEASE ATTACH COPY OF CURRENT IMMUNIZATIONS.

Height: _____ Weight: _____Blood Pressure: _____ / _____ Pulse: _____ bpm_____

Vision: R 20/_____ L 20/_____ Corrected: Yes / No Contacts: Yes / No Glasses: Yes / No

Pupils: Equal_____ Unequal _____ Hearing: R _____ L_____

Indicators	Normal		Abnormal Findings	Initials
Head/Neck	☐ Yes	☐ No		
Eyes / Sclera /Pupils	☐ Yes	☐ No		
Ears	☐ Yes	☐ No		
Nose / Mouth / Throat	☐ Yes	☐ No		
Heart: Murmur / Rhythm	☐ Yes	☐ No		
Lungs: Auscultation/Percussion	☐ Yes	☐ No		
Chest Contour	☐ Yes	☐ No		
Skin	☐ Yes	☐ No		
Abdomen: Assessment (include liver, spleen)	☐ Yes	☐ No		
Tanner Stage: Testes/Onset of Menses	☐ Yes	☐ No		
Hernia	☐ Yes	☐ No		
Neck/Back/Spine: Range of Motion	☐ Yes	☐ No		
Scoliosis	☐ Yes	☐ No		
Upper Extremities	☐ Yes	☐ No		
Lower Extremities	☐ Yes	☐ No		
Neurological: Balance & Coordination Romberg	☐ Yes ☐ Yes	☐ No ☐ No		
Heel Walk	☐ Yes	☐ No		
Tandem Walk	☐ Yes	☐ No		
Toe Walk	☐ Yes	☐ No		
Nose Touch	☐ Yes	☐ No		
Allergies:				
Additional observations:				

CLEARANCE: A. Student may participate in Physical Education: ☐ Yes ☐ No

B. ***NOT CLEARED*** for Physical Education:

Diagnosis:_____

Recommendations:_____

Provider's Signature:_____

Date of Exam: _____

Physician/Provider's Stamp