SPRINGFIELD PUBLIC SCHOOLS
SPRINGFIELD, NEW JERSEY 07081
HEALTH HISTORY

-To be completed by parents / guardian of children grade 3 and over-

Student's Name _____
Last First Middle

Birth Date_____ School_____ Grade _____

Parent/Guardian Name (Male)_____ (Female)_____
Physician's name _____ Dentist's name_____

Address_____ Address_____

Phone_____ Phone_____

Other source(s) from which the student receives health care: (If none, write "None)

_____

To the best of your knowledge, does your child have any problems which may affect his/her learning in school, cause you any concern and/or may be important for school staff to know? Please check "yes" or "no" for each of the following questions:

	Yes	No
Do you have any concerns about your child's general health (eating and sleeping habits, bowel of bladder, posture, teeth, skin, menstruation, weight, etc?…….	___	___
Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes, wear glasses of contact lenses)?.....	___	___
Does your child have any ear of hearing problems (frequent earaches, difficulty hearing, draining ear, use of hearing aid, etc.)?.....	___	___
Does your child have any speech problems (difficulty having speech understood, stammering, delayed speech development, etc.)?.....	___	___
Does your child have any allergies (foods, insects, drugs, pollens, etc.)?.....	___	___
Does your child have any other specific sickness or problem which might, in your opinion, affect his/her school performance or program?.....	___	___
a) Has your child received any medical of other evaluation, the findings of which could help school personnel in meeting his/her health of educational needs?.....	___	___
b) Does this problem require any special health care in the school?.....	___	___
c) Does your child take medication?.....	___	___
Do you have any concerns about your child's developmental behavior or emotional well-being of which the school should be aware?.....	___	___

Please complete back of Health History

REMARKS: Please explain any "yes" answer(s).

_____

_____

_____

_____

I would like to discuss my child's health with: (Please check title)

_____School Nurse
_____School Social Worker
_____School Guidance Counselor
_____No one at this time
_____Teacher
_____School Psychologist
_____Principal of School

PART TWO

1. Does this child have a health condition(s) which may require EMERGENCY ACTION while he/she is at school: (e.g. seizure, severe reaction to insect sting, allergy, asthma, bleeding problems, diabetes, and heart problem)? Yes ____ No ____
If yes, please describe.

_____

_____

_____

2. Is there any evidence for concern in the areas listed below?

Health Area	Yes	No
Vision…….	___	___
Hearing……	___	___
Speech/Language……...	___	___
Development……..	___	___
Physical illness/impairment……...	___	___
Adjustment…….	___	___
Nutrition……..Overweight……..Underweight…….	___	___

REMARKS: Please explain "yes" answer(s).

_____

_____

_____

Yes No

3. Is the student on long-term medication?..... ___ ___
If "yes" please describe: _____

4. Should there be any restriction on physical activity or physical education in school?
Yes No
If "yes" specify nature and duration or restriction. ___ ___

_____

_____ _____ _____
Signature of person completing Health History Relationship to child Date