

LYNDHURST SCHOOLS
SPECIAL MEDICAL INFORMATION FORM

Student _____ Date _____

Address _____ Phone _____

Grade _____

Is your child currently under medical care? • Yes • No

If yes, what is the medication? _____

Is your child presently receiving any other type of therapy or treatment? • Yes • No

If yes, please explain briefly. _____

In the past, has your child ever received any therapy or treatment? • Yes • No

If yes, what was the problem? _____

When was treatment received? _____

Where was it administered? _____

Is there anything you feel we should know in order to assist your child in adjusting to the school environment? _____

Has your child ever been evaluated by a Child Study Team? • Yes • No

If yes when? _____

Parent/Guardian Signature

Date

LYNDHURST SCHOOLS
HEALTH HISTORY QUESTIONNAIRE
Must be completed by parent or physician

Student's Name: _____

	Yes	No	Date	Description/Reason
Allergies	•	•	_____	_____
Asthma	•	•	_____	_____
Blood Disorders	•	•	_____	_____
Cancer	•	•	_____	_____
Chicken Pox	•	•	_____	_____
Headaches	•	•	_____	_____
Hearing Problem/Hearing Aid	•	•	_____	_____
Heart Disease	•	•	_____	_____
Hepatitis	•	•	_____	_____
High/Low Blood Pressure	•	•	_____	_____
Hospitalization	•	•	_____	_____
Kidney/Urinary Tract Problem	•	•	_____	_____
Medication Reactions	•	•	_____	_____
Menstrual Disorder	•	•	_____	_____
Mononucleosis	•	•	_____	_____
Muscular Disorder	•	•	_____	_____
Orthopedic Disorder	•	•	_____	_____
Rheumatic Fever	•	•	_____	_____
Scoliosis	•	•	_____	_____
Seizure Disorder	•	•	_____	_____
Strep Infections	•	•	_____	_____
Surgery	•	•	_____	_____
Ulcer/Gastrointestinal Disorder	•	•	_____	_____
Visual Problem/Glasses/Contact Lenses	•	•	_____	_____
Other	•	•	_____	_____

Is the student under the care of a physician? Yes• or No• If yes, give reason below.

Does the student take any regular medication? Yes• or No• Please name medication and dosage below.

Are there any other physical emotional conditions that might bear on this child's abilities or performance?

Parent or Guardian Signature: _____ Date: _____

**LYNDHURST PUBLIC SCHOOLS
LYNDHURST , NEW JERSEY**

Student Medical Examination/Immunization Record
REQUIRED FORM TO BE COMPLETED BY A LICENSED HEALTH PROVIDER

(Student's Name) _____

Sex: M [] F []

(Date of Birth) _____

(Grade) _____

(School Term) _____

PLEASE DOCUMENT IMMUNIZATIONS BELOW

DPT	#1	#2	#3	#4	#5
Tdap					
Polio Vaccine	#1	#2	#3	#4	#5
MMR	#1	#2			
HIB	#1	#2	#3	#4	
Hepatitis B	#1	#2	#3		
Varicella	#1	#2			
Prevnar	#1	#2	#3	#4	
Hepatitis A	#1	#2			
Meningococcal (after 11 th birthday)					
HPV					
Other					
Tuberculin Test Type: PPD	Date: _____		Results: _____		

Systems Review:

	Normal	Abnormal		Normal	Abnormal
Appearance			Glands		
Nutrition			Heart		
Skin			Lungs		
Head			Abdomen		
Eyes			Reflexes		
Ears			Spine		
Nose			Feet		
Throat			Neurological		
Teeth			Speech		
Allergies			Other		

Height: _____

Weight: _____

Blood Pressure: _____

Vision: R: _____ L: _____

B: _____

Glasses [] Contacts []

Hearing: R: _____ L: _____

Please list any medical history and/or medication required.

Student may participate in athletics/physical education: (NO) _____ (YES) _____

If NO, specify: _____

Duration: _____

(Physician's Signature)

(Exam Date)

Physician STAMP

(Physician-please print)

(Phone)

(Address)