



Mount Arlington Public Schools
Optional New Student Health Inventory

1. Does your child have any history of congenital anomaly? Y or N
2. Has your child had any surgeries, including ear tube surgery (myringotomy)? Y or N
3. Has your child had any hospitalizations, including for prematurity? Y or N
4. Does your child get frequent ear infections? Y or N
5. Does your child have a history of Strep infections? Y or N

If yes, explain and list what year(s) _____

6. Does your child have a heart murmur? Y or N

If yes, explain: innocent, or followed by a cardiologist? _____

7. Has your child ever lost consciousness? Y or N

Please explain _____

8. Does your family have a history of hereditary heart disease: Y or N
9. Family history of sudden cardiac arrest, heart attack, or stroke at an early age, such as under 40? Y or N

Please list _____

10. Does your child ever get headaches? Y or N Diagnosed migraines? Y or N
11. Does your child get frequent nosebleeds? Y or N
12. Does your child occasionally wet or have bowel movements in their pants? Y or N Circle the issue.
13. Please indicate if your child has developmental concerns: Y or N

If yes, explain _____

14. Please indicate if you have behavioral concerns for your child: Y or N

If yes, explain _____

15. Please indicate if you have mental health concerns for your child: Y or N

If yes, explain _____

Please look at the following and circle all that apply. History of Heart Disease, Hepatitis, Lyme Disease, Mononucleosis, Neuromuscular Disorder, Autoimmune Disorder, Juvenile Rheumatoid Arthritis, Cancer, Varicella, Measles, Mumps, Rubella, Concussion.

If you circled any of the above please explain and give the year of diagnosis: _____

If there is something you would like to share that is not on the list above or on the front of this form, that you feel is important for the health office to know to best care for your child, please elaborate here:

Parent Printed Name

Parent Signature

Date