ROXBURY TOWNSHIP PUBLIC SCHOOLS

STUDENT HEALTH HISTORY

Child's name_____Gender_____Birth date _____

Physician_____Phone number_____

Has your child seen a dentist? ____Yes ____ No Dental concerns_____

Has your child seen an eye doctor?____Yes _____ No Wearing glasses?____

Has your child ever had any of the following?

Yes	No	Condition	Yes	No	Condition
☐	☐	Anemia	☐	☐	Asthma
☐	☐	Bladder/Kidney issues	☐	☐	Bronchitis
☐	☐	Chicken pox (date:_____)	☐	☐	Concussion (date:_____)
☐	☐	Convulsions/Seizure disorder	☐	☐	Diabetes
☐	☐	Encephalitis	☐	☐	Eye problems
☐	☐	Fever over 104 degrees	☐	☐	Headaches/migraines
☐	☐	Hearing loss	☐	☐	Heart disease
☐	☐	Hepatitis	☐	☐	Hernia
☐	☐	Leg/joint pain	☐	☐	Lyme disease (date:_____)
☐	☐	Meningitis	☐	☐	Mononucleosis
☐	☐	Neuromuscular disorder	☐	☐	Nosebleeds
☐	☐	Otitis media (ear infections)	☐	☐	Pneumonia
☐	☐	Psychological evaluation	☐	☐	Rheumatic fever
☐	☐	Scarlet fever	☐	☐	Skin problems
☐	☐	Speech concerns	☐	☐	Stomach aches
☐	☐	Strep throat	☐	☐	Surgery (date:_____)
☐	☐	Tonsillitis	☐	☐	Tuberculosis

Please complete back side

Please explain any “YES” responses from the first page:

_____
_____
_____
_____
_____
_____

Has your child had any reaction to:

Foods: _____ Medicine: _____
Bee/insect stings: _____Immunizations:_____
Other:_____ Please explain:_____

Is your child currently taking any medication at home?: _____
Will your child need medication during the school day?:_____
What is the reason for the medication? _____

Does your child have any health concerns or congenital disorders that you feel may affect your child's learning?_____
_____
_____

Are there any health concerns or physical restrictions that you feel may affect your child’s ability to participate in physical education? **If so, please provide further documentation from the treating physician.** _____
_____
_____

Is there any other health concern that you would like to share with us?_____
_____
_____

Date:_____ Parent/Guardian signature:_____