# *River Edge Elementary Schools-River Edge, NJ*
# *Health History Form*

***Demographics***

Child's Name: _____Gender: M F

Phone #: _____Place of Birth: _____ Birth Date: _____

Primary Language: _____ Secondary Language: _____

Address: _____

Father's Name: _____ Mother's Name: _____

Siblings: Name: _____ Age: _____ Grade: _____
Name: _____ Age: _____ Grade: _____
Name: _____ Age: _____ Grade: _____

Child's Physician Name: _____ Phone #: _____

Hospital Preference: _____

***Birth History***

Child Delivered at _____ weeks Delivery Weight: _____

Did the mother have any illness during her pregnancy? What? _____

***Developmental History***

Did you notice any delay or abnormal behavior in your child's early growth years? Yes No Explain:
_____
_____
_____

***Medical History of Child***

Any history of head injuries, head trauma, or any diseases of the Brain? Yes No Explain: _____
_____

Any Hospitalizations for an Operation, Accident, or Medical Illness? Yes No Explain:
_____

Allergies:
Food: _____
Type of Reaction: _____ Last Occurrence: _____

Medication: _____
Type of Reaction: _____

Pollen/Seasonal Allergies? Yes No Type of reaction: _____

Bee Sting Allergy? Yes No Reaction: _____

Allergy to Animals? Yes No Reaction: _____

Other Allergies? _____

History of Illnesses: Check all that apply:
ASTHMA BRONCHITIS CANCER EAR INFECTION EAR TUBES
DIABETES ECZEMA SKIN DISORDERS SEIZURES/CONVULSIONS
HEARTDISEASE

OTHERS: _____

Is your child on any medications? Yes No

Medication: _____ Reason: _____
Medication: _____ Reason: _____
_____

Does your child wear glasses or contact lens? Yes No

Any problems with: (Circle)

SPEECH VISION HEARING PHYSICAL LIMITATIONS

Explain: _____

ADDITIONAL COMMENTS OR CONCERNS ABOUT YOUR CHILD:

Signature/Release of Information:

As parent/Guardian of _____, I hereby authorize the release of pertinent medical information about my child to those professional staff involved in his/her care or instruction.. This consent is valid in the River Edge Public School District and may be revoked by myself at anytime in writing.

_____ _____ _____
SIGNATURE PRINT NAME DATE