HEALTH QUESTIONNAIRE

Paramus Public Schools

Parents: Please complete this Health Form

Child's Name _____ Birth Date _____

Parent(s)/Guardian(s) _____ School _____

Question	Yes	No	Explain All "Yes" Answers
Were there any problems during pregnancy and/or birth?			
Do you have any concerns about your child's health (eating, sleeping, teeth, weight, skin, etc.?)			
Has your child ever had any eye problems (difficulty seeing, crossed eyes, squinting, frequently red, water)?			
Has your child ever had an eye exam? Date: Result_____.			
Does your child wear glasses? All day?			
Has your child ever had any ear or hearing problems (frequent earaches, difficulty hearing, tubes in ears)?			
Has your ever had a hearing test? Date? Has your child ever had a hearing evaluation? Date?			
Does your child wear hearing aids?			
Did your child have any delays in motor skills?			
Does your child have any speech problems (difficult to understand, stuttering, slow speech development)?			
Has your child ever had speech therapy? Date?			
Does your child have any other physical problems or impairments which might affect normal academic progress or participation in the usual school program?			
Should there be any restriction of physical activity in school?			
Does your child have any psychological, emotional or behavioral problems which might affect school performance?			
Has your child had any accidents or illnesses serious enough to require hospitalization?			
Has your child had any broken bones?			
Is your child on any daily or long term medication?			
Does your child have any health problem which might require emergency action while he/she is at school (seizures, insect sting allergy, bleeding problem, diabetes, severe asthma, etc)?			
Is there a family history of chronic illness or learning problems?			

HEALTH HISTORY FORM

Paramus Public Schools

Parents: Please complete this Health Form

Child's Name _____

Condition	Yes	No	Date	Explanation
Asthma				
Allergic to drugs				
Allergies – food, environment				
Chicken pox				
Seizure Disorder				
Diabetes				
Ear Infections				
Hearing problems				
Emotional problems				
Heart disease				
Hepatitis				
Kidney disease				
Mononucleosis				
Nosebleeds				
Pneumonia				
Scarlet fever				
Strep infection				
Speech difficulties				
Concussion				
Fractures				
Operations				
Severe injuries				
Other hospitalizations				
Other conditions				
Other injuries				

Is your child taking medications? _____ Name of drug(s) _____

If yes, for what condition(s)? _____

"I give my permission for the school nurse to share all health information with the faculty as needed."

Signature of Parent/Guardian _____Date _____

Nurse's Summary _____

_____

PARAMUS PUBLIC SCHOOLS
Paramus, New Jersey

STUDENT PHYSICAL EXAMINATION FORM

For Grades pre K through Grade 4

All students in Early Childhood, Kindergarten, grades three, six and nine, as well as all new students in Paramus Public Schools, are required to have a physical examination. Please arrange for the necessary examination with your child's health care provider and return this completed form to the school nurse (within 30 days for all new students).

No child will be allowed to participate in physical education classes without this examination and recommendation by the examining healthcare provider.

Name _____ Date of Birth _____ Grade _____

PHYSICAL EXAM: Height _____ Weight _____ B/P _____ Pulse _____

Vision _____ without correction: R 20/ _____ L 20/ _____ Hearing: Right _____

_____ with correction: R 20/ _____ L 20/ _____ Left _____

Urine _____ Hgb/Hct _____
(protein, sugar)

Skin – Scalp _____ Acne _____ Eczema _____

Eyes: Lids_____ Conjunctiva_____ Pupils_____ Ears:Canal_____ Eardrum _____

Nasal passages _____ Throat _____ Tonsils _____ Teeth _____

Neck _____ Heart _____ Lungs _____

Abdomen _____ Hernia _____Genitalia _____ Menses _____

Orthopedic: Posture _____ Spine _____ Feet _____ Extremities _____

Operations _____ Injuries _____

Allergies (include food, drug, insect bites): _____

Does student take any medication on a regular or prn basis? ☐ **Yes** ☐ **No**

Name of medication / dosage: _____ Reason _____

Significant past illnesses? _____

Current and / or health problems (asthma, ADHD, etc.)? _____

Significant family medical history _____

Full physical education program recommended? ☐ **Yes** ☐ **No**

If not recommended, reason:_____

Educational Relevance of findings, if any _____

Impact of current medical management on student's learning processes, if any _____

_____

IMMUNIZATION RECORD

Vaccine	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year
DTP/Td					
Tetanus, diphtheria,& acellular pertussis (Tdap)					
Polio					
MMR					
Measles					
Mumps					
Rubella					
HIB					
Hepatitis B					
Varivax					
Pneumoccocal Vaccine					
Influenza Vaccine					
Meningococcal Vaccine					
Other					

Mantoux: Date administered _____ Date read _____

Results: ☐ Negative ☐ Positive Induration _____mm

Chest X-Ray: Date _____ Results _____

Medication (if prescribed):_____

Date started _____ Date finished _____

Health Care Provider Name / Address / Phone (Please Print or Stamp):

Health Care Provider Signature: _____ **Date of exam**:_____

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