RIDGEWOOD PUBLIC SCHOOLS
Ridgewood, New Jersey

Students New To The Ridgewood Public Schools – Grades K-5

SCHOOL HEALTH HISTORY ENTRANCE FORM

Please complete the following and return to the school nurse as soon as possible.

Child's Name_______________________________ Sex M ☐ F ☐ Birth Date ____________________
(Last) (First)

Grade________ School ________________________ Home Address ______________________________

Father's Name ______________________________ Mother's Name______________________________

Home Phone ________________________ Work Phone Mother ____________________ Father______________
Cell Phone: ____________________ Cell Phone ______________

Siblings, Names/Ages____

Language(s) spoken at home (other than English)____

II. BIRTH & DEVELOPMENTAL HISTORY

Birth Weight: Pounds ________ ounces

Gestation (Duration of Pregnancy) ________ weeks or ________ months

Pregnancy: Illness of Mother Yes☐ No ☐ If yes, explain: ____________________________________

____

Other areas of concern -- Yes☐ No ☐ If yes, explain: ______________________________________

Problems/labor & deliver-- Yes☐ No ☐ If yes, explain: ______________________________________

Growth and Development: Age child –

Sat alone ________ Crawled ________ Walked ________ First Spoke ________ Spoke in sentences __________

Coordination (difficulty) Yes☐ No ☐ If yes, explain: ______________________________________
(fine motor, large muscle, other areas of concern)

II. FAMILY MEDICAL HISTORY (Please specify: Allergies, Respiratory, Heart, Diabetes, Cancer, Other)

Father_____________________________________ Mother ___________________________________

Siblings____________________________________ Relative__________________________________

III. HEALTH HISTORY (Please check appropriate column, note year, and explain where applicable.)

Allergy Types	Reaction	School Restriction
Bee/Insect		
Drugs		
Food		
Pollen		
Skin		
Other (i.e. latex)		

Other Conditions	No	Yes	Year(s)	Explain
Asthma/Reactive Airway Passage				
Blood Disorder				
Cancer				
Concussion/Head Trauma				
Diabetes				
Digestive/Feeding Disorder				
Diseases, i.e. chicken pox				
Mononucleosis				
Mumps				
Measles				
Dietary Restrictions				
Emotional Problems				
Genitourinary Problems				
Hearing Difficulty				
Heart Disease (defects)				
Hospitalization(s)				
Severe Infections				
Kidney Disease				
Neuro-muscular Disorders or prosthesis				
Organs missing or impaired function of paired organs; i.e. kidneys, testes, eyes				
Orthopedic Disorder				

Other Conditions	No	Yes	Year(s)	Explain
Central Nervous System Disorder				
Rubella				
Skin Disorder				
Speech Impairment				
Surgical Procedure(s)				
Vision Problems				
Glasses/Contacts				
Other (list and explain) serious illnesses, accident, genetic disorders)				

A. Is the student receiving medication? Yes☐ No ☐ If yes, complete the following:

Medication(s)	Dose	Times	Reason	Date Prescribed	Prescribing Physician

B. Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

Yes☐ No ☐ If yes, explain: ______________________________

____

____

C. Does the student require an special procedures and/or treatments?

Yes☐ No ☐ If yes, explain: ______________________________

____

____

D. Is the student current under treatment for any health conditions?

Yes☐ No ☐ If yes, complete the following:

Condition **Physician** **Treatment**

____

____

____

E. **Has the student had a vision screening?**

Yes☐ No ☐ If yes, please report results:
________________________________ (date) ____________________

F. **Has the student had a hearing screening?**

Yes☐ No ☐ If yes, please report results:
________________________________ (date) ____________________

G. **Has the student had any special medical examinations?**

Yes☐ No ☐ If yes, complete the following: (i.e., ophthalmologic, neurological, orthopedic, etc.):

Specialty	Physician	Exam Date	Diagnosis	Recommendation

H. **Has the student had any experience(s) which you feel may affect his/her physical, mental, and/or social development?**

Yes☐ No ☐ If yes, please explain:

____

____

____

____

I. **Please complete: Last medical examination:**

Date:	Reason
Physician:	Findings
Address:	
Phone#:	

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

As parent/guardian of the above named student, I hereby allow for the sharing of information between the student's health care team and the nurse, to divulge necessary information to necessary staff.

______________________________ ______________________________

Date ***Signature of Parent/Guardian***

/dc/1/2010