MOORESTOWN TOWNSHIP PUBLIC SCHOOLS
Health History
To be completed by parent or guardian and returned to the school nurse

Student's name_____Date of birth_____
Sex: Male___Female___ School_____Grade_____
Most recent physical examination: Date_____Name of examiner_____
Purpose of exam: Routine check-up_____Illness/Injury_____
Country of birth_____# of years in USA:_____
Family: People living in the home_____
_____

Prenatal history: Birth weight_____Premature birth?_____
# of weeks gestation_____Birth defects_____
Pregnancy complications_____Newborn complications_____

Health status; Past or present problems and illnesses. If yes, state dates:

___Cystic fibrosis	___Hemophilia	___Frequent urination
___Chicken pox	___Eczema/dermatitis	___Kidney problem
___Diabetes	___Other skin problem	___Urinary tract infection
___Sickle cell	___Ear infections	___Bedwetting
___Heart disease	___Hearing problem	___Bowel problems
___Heart murmur	___Vision problem	___Frequent Constipation
___Mononucleosis	___Eyeglasses	___Frequent diarrhea
___Lyme disease	___Pinkeye	___Fainting
___Strep throat	___Frequent nosebleeds	___Seizures
___Scarlet fever	___Frequent headaches	___Neurological problems
___Hepatitis	___Frequent stomachaches	___Excessive fears
___Arthritis	___Frequent sore throats	___Sleep problems
___Pneumonia	___Foot problem	___Back problem
___Meningitis	___Sinus problem	___Other:_____

Allergies and the nature of reactions (including allergies to food, medication, and insects stings)
_____
_____
Does your child have asthma?_____If yes, circle: mild, moderate, severe, exercise-induced, illness-induced. Age of diagnosis:_____. Most recent asthma attack:_____
Medications and treatments that your child needs on a regular basis_____
_____
Serious accidents & injuries (e.g. head injuries, fractures, stitches)_____
_____
List all surgeries and dates (use back of sheet if needed)_____
_____
Hospitalizations since birth (reasons and dates)_____
_____
Does your child have any restrictions on his/her activities?_____
_____
Speech problems_____
Is there color-blindness in your family?_____
Are there any situations in the home which might affect your child's learning?_____
_____
Is there anything about your child's health that you think is important for us to know?_____
_____

Parent/guardian_____Date_____