ELEMENTARY HEALTH OFFICE/NEW ENTRANT QUESTIONNAIRE

Student's Name ______________________________ ID#__________ D.O.B.________

Birthplace ____________________________ Age ________ Sex ______ Grade ________

Please check the following questions and explain any "Yes" answer on the space provided.

MEDICATIONS:

Does your child take any daily medications? Yes ______ No ______

If Yes, please list daily medications and doses: ______________________________

Will your child require medication given in the school? Yes ______ No ______

ALLERGIES: Is your child allergic to any of the following:

Medications: Yes ______ No ______

If Yes, please list: ______________________________

Seasonal Allergies: Yes ______ No ______

If Yes, please list: ______________________________

Bee Sting/Insect Bites: Yes ______ No ______

Food Allergies: Yes ______ No ______

If Yes, which foods? ______________________________

Type of Reaction? ______________________________

Type of Medication needed for reaction? ______________________________

Asthma: Yes ______ No ______

If Yes, frequency of attacks? ______________________________

Known triggers? ______________________________

Current daily asthma medications? ______________________________

Normal Peak Flow ______________________________

HEART DISEASE/HEART MURMUR: Yes ______ No ______

If Yes, are there any limitations in activity? ______________________________

PLEASE NOTE: A doctor's note is required stating there is no limitations of activity to participate in gym, sports or recess.

KIDNEY DISEASE: Yes ______ No ______

DIABETES: Yes ______ No ______ If Yes, we will discuss and formulate careplan for the school year.

SEIZURES: Yes ______ No ______ If current seizure disorder, we will meet to formulate careplan for the school year.

Medications/Limitations: ______________________________

Date of last seizure: ______________________ Type of Seizure: ______________________

LYME DISEASE: Yes ______ No ______

If Yes, date of diagnosis: ____________________ Current medications/limitations? ____________________

GLASSES: Yes ______ No ______

If Yes, when are they worn? ____________________

HEARING DIFFICULTIES: Yes ______ No ______

If Yes, please explain: ____________________

FREQUENT EAR INFECTIONS: Yes ______ No ______

If Yes, approximately how many infections and what age(s)? ____________________

FREQUENT STREP INFECTIONS: Yes ______ No ______

History of any of the following?

HEAD INJURIES: Yes ______ No ______ HOSPITALIZATION: Yes ______ No ______

BROKEN BONES: Yes ______ No ______ SURGERIES: Yes ______ No ______

If you answered Yes to any of the above, please give dates and explain:

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Please list any other disabilities, limitations, or health concerns: ____________________

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Previous School Attended: ____________________ Phone: ____________________

Parent Signature: ____________________ Date: ____________________

Does this child have any health insurance including NJ Family Care/Medicaid, Medicare, private or other?

Yes ______ If Yes, name of insurance company ____________________

No ______ NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents.

For more informations call 800-701-0710 or visit www.njfamilycare.org to apply online.

You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: ____________________ Printed Name: ____________________ Date: ______________

Written consent required pursuant to 20 U.S.C. 1232g (b)(1) and 34 C.F.R. 99.30(b)