WOODBRIDGE TOWNSHIP SCHOOL DISTRICT

STUDENT HEALTH RECORD

Parent Questionnaire

Child's Name_____ Birth Date _____ Sex _____

Mother's Name _____ Father's Name _____

With whom does the child live? _____ Who is legal guardian? _____

Part I. **Immunizations**

Please attach an official copy of immunization records.

Part II. **Perinatal and Developmental History**

1. Did the mother have any unusual problems/illnesses during the pregnancy or the birth, such as breech, forceps or cesarean delivery? Yes ____ No ____ If yes, explain briefly: _____
2. Was this infant born full term _____ early _____ late _____?
3. What was this infant's birth weight? _____
4. Did the infant have any sickness or problems while in the hospital, such as jaundice, seizures or difficulty breathing? Yes____ No___ If yes, explain briefly: _____
5. Please give approximate age at which the child: sat up alone _____ walked _____

   said single words_____ said sentences_____ was toilet-trained _____
6. How does this child's development compare to other children, such as brothers, sisters, or playmates? About the same _____ slower _____ faster _____.

Part III. **Health Conditions** (please check any this child has had)

_____ chicken pox (what year?_____)
_____ diabetes
_____ eye problems, poor vision or crossed eyes
_____ frequent ear infections
_____ tubes in ears
_____ frequent headaches
_____ frequent nosebleeds
_____ frequent sore throat infections
_____ high fevers

____ poor hearing
____ seizures
____ epilepsy
____ sickle cell disease
____ toothaches/dental infection
____ other? List: _____
_____
____ Is your child sick a lot? _____
If yes, please explain: _____

Part IV: **Allergies and Asthma**

1. Please list and describe allergies or reactions to:

   Medicines/drugs _____

   Foods/plants/others _____

   Bee or wasp stings _____
2. Recommended treatment if allergy is severe: Allergy shots? _____
3. Does this child have asthma that has been diagnosed by a doctor? Yes _____ No _____
   If yes, what treatment has been prescribed? _____

Part V: **Injuries, Illnesses and Surgeries**

Please list any severe injuries, illnesses or surgeries:

Injuries, Illnesses, Surgeries	Age of Child	If Hospitalized Check Here
_____	_____	_____
_____	_____	_____

Part VI: **Additional Information**

1. What medications are given daily? _____
2. What medications are given frequently, but not daily? _____
3. This child is usually: very active ____ normally active _____ rather inactive _____
4. Do any family members have long-term illnesses such as diabetes or high blood pressure? If so what? _____

Do you have any other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, please explain: _____

Completed by _____ Date _____

Relationship to child _____ I would like a conference with this school nurse: Yes ____ No ____