CEDAR GROVE PUBLIC SCHOOLS
STUDENT HEALTH HISTORY
To Be Completed by the Parent—Return and Review with the School Nurse

NAME_________________________________ DOB____________ DATE__________

Address_____________________________________ Phone Contact_______________

Father's Name___________________________ Mother's Name______________________

BIRTH HISTORY:

Uncomplicated: _________ Complicated: ________
Birth Weight: _____lbs._____oz.
Age Walked Alone: ___________________ Age Said Few Words: _______________
Siblings: Age______ M/F Age______M/F Age______ M/F Age______ M/F

PARENT/SIBLING HISTORY: (Optional)

Are there any significant health concerns we should be aware of?
Father____
Mother____
Sibling(s) ____

STUDENT ALLERGY HISTORY:

	Reaction to Allergen
Food___________________________________	________________________________
Environmental___________________________	________________________________
Insect Stings____________________________	________________________________
Latex_________________________________	________________________________
Medications____________________________	________________________________

MEDICATIONS:

Does your child take any medication, or need an EpiPen for allergic reactions?
Daily Medication____
PRN (as needed) Medication____
EpiPen(Adult)________ EpiPen Jr.________ Last Time Epi-Pen Used?_____________

INJURIES/OPERATIONS:

Fractures______________________________ Surgery__________________________
Head Injuries___________________________ Sutures__________________________
Has your child ever visited the Emergency Room? Yes___ No___ How often? ___________
If yes, please explain____
Other____

ILLNESSES:

Asthma	_____	**Epilepsy/Convulsions**	_____	**Respiratory Infections**	_____
Chicken Pox	_____	**Febrile Seizures**	_____	**Skin Problems**	_____
Diabetes	_____	**Stomach Problems**	_____	**Sleeping Problems**	_____
Ear Infections	_____	**Mononucleosis**	_____	**Strep Throat**	_____
Other	_____	**Comments____**			

SPECIAL CONSIDERATION:

Hearing Concerns______ Hearing Aid_____ Vision Concerns_______ Glasses___________
Bowel/Bladder Concerns____
Physical Therapy____________ Occupational Therapy__________ Speech______________
Takes a Nap_____ Breath holding_____ Temper Tantrums___________________________
Emotional Issues___________________________ Other____________________________
Attends Pre-School/Nursery School - Yes or No - Name of School: _____________________

SCHOOL NURSE SIGNATURE: ____