BERGENFIELD PUBLIC SCHOOL DISTRICT
CONFIDENTIAL HEALTH HISTORY
Pre-Kindergarten – Fifth Grade

A. **GENERAL INFORMATION – Please Print**

Male _____

Female _____

_____ _____ _____

Student's Last Name / First Name | Birth Date | Grade

_____ _____

Student's Address | Telephone Number

_____

Country/ State of Birth

If transferring in, please state:

_____ _____

Name of Prior School | Address - City & State

B. **PLEASE FILL IN THE FOLLOWING INFORMATION:**

_____ _____ _____

Parent/Legal Guardian | Relationship to Student | Cell Phone

_____ _____ _____

Parent/Legal Guardian | Relationship to Student | Cell Phone

C. I hereby give permission for the school to take necessary action in an extreme emergency, including permission for the Bergenfield Ambulance Corps to transport my child to the following hospital of my choice. (Check one)

☐ Englewood Hospital ☐ Holy Name Hospital ☐ Hackensack Medical Center ☐ Nearest One

EVERY EFFORT WILL BE MADE TO CONTACT THE PARENT/GUARDIAN

Information on this form will be shared with appropriate staff members if it is pertinent to the child's health /safety.

_____ _____

Date | Signature of Parent/ Legal Guardian

D.**FAMILY HEALTH HISTORY:** Include significant information such as heart disease, diabetes, cancer, TB, emotional or mental illness, etc.

Mother's Health _____ Father's Health _____

Names of other children	Birth Date	Sex	General Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

E.**BIRTH HISTORY:** Were there any unusual problems during pregnancy or delivery? _____

If so, please explain: _____

Was the baby full term? _____ Premature? _____ Birth weight _____

Explain any significant health problems your child may have had as an infant:

_____

F.**DEVELOPMENTAL HISTORY PAST/PRESENT:** Has your child demonstrated any problems in the following areas? If so, please explain:

Speech _____

Walking _____

Vision _____

Hearing _____

G.**MEDICAL HISTORY:** Please check if this is a problem area and explain:

☐ Allergies _____

Food (please list products) _____
Insect bites or stings _____
Eczema (skin rashes) _____
Medications _____

☐ Asthma _____
Date of onset _____ Frequency _____ Type of reaction _____
Medication: (Name, dosage, frequency given) _____

☐ Dental _____

☐ Ear Infections _____

- ☐ Severe respiratory infections/illness _____
- ☐ Convulsive disorder _____
- ☐ Diabetes _____
- ☐ Kidney _____
- ☐ Heart _____
- ☐ Stomach/Intestinal _____
- ☐ Operations _____
- ☐ Injuries _____
- ☐ Other _____

Please indicate the approximate dates for any diseases your child may have had:

Chicken Pox _____ Other _____

H. **CURRENT CONSIDERATIONS:** Is your child under medical treatment at present? _____

For what? _____

If so, by whom? _____

Physician's Name and Address

Does your child wear any type of medical appliance, i.e., hearing aid, brace, shoe cookie? _____

_____

Does your child take any medication? _____ Reason _____

Name of medication _____ Dosage _____

How often _____

Must medication be given during school hours? _____ (A physician and parent statement is required for any medication to be given in school.)

Is there any medical reason your child should not take Physical Education/Gym? _____

If yes, why _____

A physician's statement is required if your child is unable to participate in physical education.

Is there any health information that you feel would be helpful in planning for your child's school year?

_____

_____

_____

_____

If there is any change in any of the above information, kindly inform the Health Office.