BERGENFIELD PUBLIC SCHOOL DISTRICT
CONFIDENTIAL HEALTH HISTORY
PRE-KINDERGARTEN

A. **GENERAL INFORMATION – Please Print**

______________________________ ________________ Male ___ Female ___

Student's Last Name / First Name Birth Date (Mo/Day/Yr)

______________________________ ________________

Student's Home Address Home Telephone Number

______________________________ ________________

Country/ State of Birth Language Spoken at Home

Hand Preference: Right _____ Left _____ Uses Both Equally _____

(Check with whom child resides):

___________________ ________________ ________________ ☐

Parent/Legal Guardian Relationship to Student Cell Phone

___________________ ________________ ________________ ☐

Parent/Legal Guardian Relationship to Student Cell Phone

Parent/Guardian's Place of Business: Telephone #: ____________________________________

____

Name of Business Address City State

Place of Business (Parent/Guardian): Telephone #: ____________________________________

____

Name of Business Address City State

Child's Pediatrician/ Physician ____

Name of Doctor

______________________________________ _______________________

Address City Telephone Number

In case of an accident or illness and you are not available, whom may we contact?

1) Name ____________________________ (Male/Female) Telephone No. _______________

2) Name ____________________________ (Male/Female) Telephone No. _______________

IN THE EVENT OF AN EMERGENCY REQUIRING AN AMBULANCE, THE BERGENFIELD AMBULANCE CORPS WILL TRANSPORT YOUR CHILD TO (Indicate Preference):

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

IN THE EVENT YOUR CHILD IS PLACED IN AN "OUT OF DISTRICT SCHOOL", HE/SHE WILL BE TAKEN TO THE NEAREST HOSPITAL.

B.**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 siblings/other children	Birth Date	Sex	General Health

C.**BIRTH HISTORY:** Were there any unusual problems during pregnancy or delivery? __________

If so, please explain: ____

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

Did the baby need oxygen?______ Did the baby stay longer than the mother in hospital?______

If yes, why? ____

Circle those problems the baby may have experienced: jaundice, convulsions, deformities, respiratory difficulties, feeding difficulties, i.e., swallowing, colic, vomiting, diarrhea, abnormal crying.

D.**DEVELOPMENTAL HISTORY (PAST/PRESENT):** Did your child attend an Infant Stimulation Center? _____ If so, which one? ____

Has your child demonstrated any problems in the following areas? If so, please explain:

Language/Speech ____

Vision ____

Hearing ____

Sitting ____

Crawling ____

Standing ____

Walking ____

Toilet Training____________ Bladder Control __________ Bowel Control __________

Does your child wear diapers?__________ During the day?________ During the night? ________

E.**MEDICAL HISTORY:** Please check if the following pertains to your child and explain:

☐ Allergies

Food (please list products) ____

Insect bites or stings____

Eczema (skin rashes)____

Hives ____

Dust/Pollen ____

Hay fever ____

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 ____________________
- [ ] Orthopedic/Muscular ____________________
- [ ] Injuries (fractures, sutures, etc) ____________________
- [ ] Operations ____________________
- [ ] Hospitalizations (Date and reason other than listed above) ____________________
  ____
- [ ] Other ____________________

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

Chicken Pox: __________ Pneumonia __________ Other __________

Is your child under the care of a specialist? Please explain:

Doctor ____________________
Dentist ____________________
Psychologist ____________________
Speech Therapist ____________________
Physical Therapist ____________________
Occupational Therapist ____________________
Other ____________________

Does your child wear?

Glasses __________ Hearing Aid __________

Medical appliance (i.e. brace, shoe cookie) ____________________
Is your child on a special diet? ____________________
If so, please describe ____________________

F. **SOCIAL/EMOTIONAL:**

Place a check on the line between the closest words which best describe your child:

Happy	-	-	-	-	-	-	-	-	-	Sad
Outgoing	-	-	-	-	-	-	-	-	-	Shy
Easy Going	-	-	-	-	-	-	-	-	-	Nervous
Separates easily (from parent/guardian)		-	-	-	-	-	-	-	-	Does not separate easily (from parent/guardian)
Plays well with others			-	-	-	-	-	-	-	Plays alone

Has your child ever experienced an upsetting emotional shock? (auto accident, death, divorce, or other situation) ______________ If so, please explain:

____

____

G. **CURRENT CONSIDERATIONS:**

If your child is presently under medical treatment, please explain:

For what? ___________________________ By whom? ___________________________

Does your child take any medication? ___________ Dosage? _________ How often? ___________

Must medication be given during school hours? ____

(A physician's and parent's statement is required for any medication to be given in school.)

H. **TRANSPORTATION INFORMATION:** Does your child have any special behavior/physical/medical problems that should be considered when transportation arrangements are made?

____

I. **ADDITIONAL CONSIDERATIONS:** Is there any additional information that you feel would be helpful in planning for your child's school year?

____

If there is any change of the above information, kindly inform the Health Office. If there are any other concerns that you wish to share with us, please contact any of the staff (teacher, principal, school nurse, therapist, or psychologist) at the school in which your child may attend. Thank you for your cooperation in completing this form. It will help make your child's pre-school experience a more fulfilling one.

I HEREBY GIVE PERMISSION FOR THE SCHOOL TO TAKE NECESSARY ACTION IN FOLLOWING MEDICAL PROTOCOL IN ANY EXTREME EMERGENCY. I AM AWARE THAT EVERY EFFORT WILL BE MADE TO CONTACT THE CHILD'S PARENT/GUARDIAN.

______________________________________ ___________________________

Signature of Parent/Guardian Date