HACKENSACK SCHOOLS
STUDENT HEALTH HISTORY

Child's Name_____ Date of Birth_____

Address_____ Phone # _____

Please complete the following health history, in order to keep our student health records current.

	YES	NO	If yes, please Indicate date	Treatment and/or restrictions recommended by physician
Allergies**	____	____	_____	_____
Asthma	____	____	_____	_____
Blood disorders	____	____	_____	_____
Chicken Pox	____	____	_____	_____
Diabetes	____	____	_____	_____
Head Injury	____	____	_____	_____
Headaches	____	____	_____	_____
Heart problems	____	____	_____	_____
Hearing problems	____	____	_____	_____
Seizures	____	____	_____	_____
Skin conditions	____	____	_____	_____
Speech/language	____	____	_____	_____
Urinary problems	____	____	_____	_____
Vision/Glasses	____	____	_____	_____
Other	____	____	_____	_____

(If needed, use back of sheet for additional information)

****Specific Allergies:** _____

Any other information related to health: Yes____ No ____

Explain:_____

_____

Has your child ever been hospitalized for illness or surgery: Yes___ No___ If yes, what year _____

Explain: _____

_____

Is your child presently taking a prescription medication: Yes____ No ____

If yes, please indicate name of medication, dosage, time of day given and reason for use.

_____

_____

Birth Weight _____ Full Term _____ Premature _____

Were there any problems during pregnancy or birth: Yes ____ No ____

Explain:_____

_____

I give my permission to share this information with appropriate school staff.

_____ _____

Signature of Parent/Guardian Rev. 1/10

ESCUELAS PUBLICAS DE HACKENSACK
REGISTRO DE SALUD ESTUDIANTIL

Nombre del nino (a)_____ Fecha de nacimiento_____

Direccion_____ Telefono _____

Favor de completar las siguentes preguntas.

	SI	NO	Al indicar "SI" de la fecha	Tratamiento/restriccion Medica por Doctor
Alergias**	____	____	_____	_____
Asma	____	____	_____	_____
Problemas de sangre	____	____	_____	_____
Varicella	____	____	_____	_____
Diabetis	____	____	_____	_____
Heridas a la cabeza	____	____	_____	_____
Dolores de cabeza	____	____	_____	_____
Problemas de corazon	____	____	_____	_____
Problemas de oido	____	____	_____	_____
Convulsiones	____	____	_____	_____
Problemas en la piel	____	____	_____	_____
Problemas en hablar	____	____	_____	_____
Problemas urinarios	____	____	_____	_____
Vision	____	____	_____	_____
Otros	____	____	_____	_____

(Favor de usar lado dorso para informacion adicional)

****Tipo de alergias:** _____

Otros problemas de salud: Si____ No ____

Explique:_____

_____

¿Ha estado hospitalizado el nino/la nina?: Si___ No___ Fecha _____

Explique:_____

¿Esta tomando su hijo/hija una medicina recetada? Si____ No____

Indique el nombre de la medicina, dosis, cuando la toma y la razon.

_____

_____

Peso del nino/nina al nacer _____ De nueve meses? _____ Prematuro _____

¿Tuvo la madre problemas durante el embarazo o el parto? Si ____ No ____

Explique:_____

_____

Tienen mi permiso para compartir esta informacion con directores de la escuela.

_____ _____

Fecha Firma de padres/guardiantes

HACKENSACK PUBLIC SCHOOLS
Hackensack, NJ 07601

NEW ENTRANTS REQUIREMENTS

Immunizations:
Documentation from a doctor or clinic is needed for: Diptheria, Pertussis & Tetanus (DPT), Polio, Measles, Mumps, Rubella (MMR), Haemophilus B Influenza (HIB), Hepatitis B, Varivax, Prevnar, Flu, and Meningitus.

Physical Exam:
All new students must have a physical exam done by their private doctor. An exam done within a year of entering school will be acceptable. Please have your family doctor complete this form and return it to school.

NAME _____ DATE OF BIRTH _____

SCHOOL _____ GRADE _____ ROOM _____

IMMUNIZATIONS: (Month, Day, Year)

DPT	/ /	/ /	/ /	/ /
Boosters	/ /	/ /		
Polio	/ /	/ /	/ /	/ /
Boosters	/ /			
MMR	/ /	/ /		
HIB	/ /	/ /	/ /	/ /
HEP B	/ /	/ /	/ /	
PREVNAR	/ /	/ /	/ /	/ /
VARIVAX	/ /	/ /		
FLU	/ /			
MENINGITIS	/ /			

MANTOUX – Date Given: ____/____/____

Result_____ Date Read:____/____/____

Please fill out immunizations for new entrant or if recent Booster has been given.

Full participation in physical education: YES____ NO____

PHYSICAL EXAMINATION: Date _____
N=Normal; if abnormal, please explain

Height _____ Wt _____ B/P _____

Vision: R _____ L _____

Hearing: R _____ L _____

Nose: _____ Heart: _____

Throat: _____ Murmur: _____

Neck: _____ Abdomen: _____

Lungs:_____ Extremities _____

Mouth: _____ Scoliosis: _____

Past Medical History: _____

_____

Accidents: _____

Operations: (Give Dates): _____

_____

Medications: _____

_____

Unusual Diseases or Contagion: _____

_____

_____

Rev 2/08

_____
Signature of Physician
Please Stamp