WYCKOFF SCHOOL DISTRICT
WYCKOFF, NEW JERSEY

HEALTH HISTORY

Name of Child: _____ Date of Birth: _____

My child has Health Insurance: _____ Y _____N Health Insurance Provider: _____

Date of last lead test: _____ Lead level test result: _____

Clearly mark with a check if your child has a history of any of the following.
Provide explanation in the space available for anything checked.

Injuries: _____ Surgeries/Hospitalizations due to Injury/Illness _____Stitches
Allergies: _____ Foods _____ Drugs _____Animals _____Environment _____Required the use of an EpiPen or other medication due to allergies
Respiratory: _____Asthma _____Reactive Airway Disease _____Hayfever _____Bronchitis/Pneumonia _____Croup _____Required the use of oral medication/inhaler/nebulizer
Bones/Joint Disease: _____Fractures/Dislocations _____Arthritis _____Lyme Disease _____Scoliosis
Cardiac: _____Rheumatic Fever _____Murmur _____High Cholesterol/High Blood Pressure _____Heart Surgeries
Ear/Nose/Throat: _____Ear Infections _____ Ear Tubes _____Hearing Loss _____Hearing Aids _____Chronic or Frequent Ear Infections _____Frequent Strep Throat _____Frequent Tonsillitis _____Frequent Sinusitis
Gastrointestinal: _____Frequent Vomiting _____Frequent Diarrhea _____Chronic Constipation _____Selective Eater
Kidney or Liver Disease: _____Urinary Tract Infections _____Hepatitis Vaccine
Neurological: _____Concussion/s _____Headaches _____Migraines _____Seizure/s
Speech: _____Delayed Speech _____Stuttering _____Difficulty with Certain Sounds
Vision: _____Crossing or Wandering Eye/s _____Color Deficiency _____Glasses _____Contacts
Birth History: _____Premature _____Difficulties at Birth
Medically Diagnosed Behaviors: _____Impulsiveness _____Inattention _____Hyperactivity
Chickenpox (Varicella):

_____Disease _____Immunization _____Neither
Dental Appliances: _____Braces _____Palate Expanders _____Retainer _____Caps
Dermatology: _____Birthmarks _____Scars _____Eczema _____Psoriasis
Diabetes: _____Insulin Pen _____Insulin Pump
Does your child take any daily medication including vitamins or herbs? _____Y _____N If Yes, please specify:
Does your child have any physical conditions not covered in this form? _____Y _____N If Yes, please specify:
Is there any additional medical information which you feel could help the school nurse and your child's teacher better understand your child?

DOCTOR'S NAME: _____ ADDRESS: _____ TELEPHONE #: _____

In a medical emergency we hereby authorize the school district to seek emergency medical assistance for our child when we cannot be reached.

_____ _____ _____
Parent/Guardian Name **Parent/Guardian Signature** Date

_____ _____ _____
Parent/Guardian Name **Parent/Guardian Signature** Date