

**CHERRY HILL**



**PUBLIC SCHOOLS**

**SCHOOL HEALTH SERVICE  
-- HEALTH HISTORY --**

School: \_\_\_\_\_

Grade: \_\_\_\_\_

**Dear Parents/Guardians:**

We would like your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current health history. Please complete this form and return it at Registration to the School Nurse. Thank you.

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Names of Parents/Guardians \_\_\_\_\_ Phone \_\_\_\_\_

List all members of household:

| Name  | Age of Children | Relationship |
|-------|-----------------|--------------|
| _____ | _____           | _____        |
| _____ | _____           | _____        |
| _____ | _____           | _____        |

If Parents/Guardians are working, who cares for child when not in school? \_\_\_\_\_

Parents/Guardians are: Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
Unmarried/Living Together \_\_\_\_\_

During the pregnancy with this child, did the mother have any medical problems (e.g., high blood pressure or kidney infection, exposure to other infections)? \_\_\_\_\_

Were there any problems during labor and delivery? \_\_\_\_\_

Please explain: \_\_\_\_\_

Did the child leave the hospital when his/her mother left? \_\_\_\_\_

If no, please explain: \_\_\_\_\_



### Child's Medical History:

At what age has the child had any of the following diseases?

|                   |                     |                       |                 |
|-------------------|---------------------|-----------------------|-----------------|
| Chicken Pox _____ | Mumps _____         | Rheumatic Fever _____ | Measles _____   |
| Strep _____       | Scarlet Fever _____ | German Measles _____  | Hepatitis _____ |
| Other _____       |                     |                       |                 |

At what age has the child had any of the following operations?

Tonsillectomy \_\_\_\_\_ Hernia Repair \_\_\_\_\_ Appendectomy \_\_\_\_\_

Other (Please Explain) \_\_\_\_\_

Does the child have any medical history of the following?

|     |    |  |
|-----|----|--|
| Yes | No | Allergies  |
| Yes | No | Convulsive Disorder                                    |
| Yes | No | Diabetes   |
| Yes | No | Physical Disability                                    |
| Yes | No | Kidney Disorder  |
| Yes | No | Heart Disorder   |
| Yes | No | Fainting   |
| Yes | No | Asthma   |
| Yes | No | Frequent Headaches                                     |
| Yes | No | Frequent Colds   |
| Yes | No | Frequent Urinary Infections                            |
| Yes | No | Frequent Sore Throat                                   |
| Yes | No | Poisoning  |
| Yes | No | Serious Burns  |
| Yes | No | Cuts Needing a Doctor                                  |
| Yes | No | Broken Bones   |
| Yes | No | Physical Abnormality                                   |
| Yes | No | Persistent Mouth Breathing                             |
| Yes | No | Frequent Digestive Disturbance                         |
| Yes | No | Frequent Pain: Joints _____ Muscular _____ Other _____ |

Has the child been hospitalized for any reason since birth? \_\_\_\_\_

If yes to any of the above, please give details: \_\_\_\_\_



**SCHOOL HEALTH SERVICE  
-- HEALTH HISTORY --  
(Continued)**

**Child's Patterns**

This section contains additional information that may be of help to your child's teacher. Please take a few minutes to answer those questions that apply.

|     |    |  |
|-----|----|--|
| Yes | No | Was he/she a baby that required a great deal of attention or care?         |
| Yes | No | Does the child presently have enuresis (bed wetting)                       |
| Yes | No | Does the child have urinary accidents during the day?                      |
| Yes | No | Does the child have bowel movement accidents during the day?               |
| Yes | No | Is the child a selective eater?  |
| Yes | No | Is another language spoken in the home? Indicate _____                     |
|     |    | At what age did the child start to walk? _____ talk? _____                 |
| Yes | No | Does the child go to bed willingly? At what time? _____                    |
| Yes | No | Does the child have nightmares?  |
| Yes | No | Does the child walk in his/her sleep?                                      |
| Yes | No | Does the child have any difficulty hearing?                                |
| Yes | No | Can you leave your child with a babysitter?                                |
| Yes | No | Does the child bite his/her fingernails?                                   |
| Yes | No | Does the child suck his/her thumb?   |
| Yes | No | Has the child attended nursery or church/synagogue related schools, etc.   |
| Yes | No | Is the child bothered by noisy environment or loud noise?                  |
| Yes | No | Does the child forget what has been said after a few minutes?              |
| Yes | No | Does the child have difficulty understanding many words?                   |
| Yes | No | Has the child ever had vision examined professionally?                     |
| Yes | No | Has the child ever had an eye injury?                                      |
| Yes | No | Has the child ever had vision questioned in preschool screening?           |
| Yes | No | Has the child ever had hearing examined professionally?                    |
| Yes | No | Did the child have frequent ear infections during the first five years?    |
|     |    | If so, how was it treated: Tubes in ears _____ Medication _____ Both _____ |
| Yes | No | Has your child ever had a professional dental examination?                 |

Is your child presently taking any medication? If so, please specify reason and type: \_\_\_\_\_

Is your child under medical treatment at present? If so, please specify: \_\_\_\_\_

Please indicate any physical condition you feel the school should be aware of: \_\_\_\_\_

What responsibilities does your child have at home? \_\_\_\_\_

What pets are in the family? \_\_\_\_\_

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What terminology does your child use for bowel movements? \_\_\_\_\_

What terminology does your child use for urination? \_\_\_\_\_

What information do you feel would be of benefit to your child's teacher? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anything more about your child's health that you think is important for school personnel (teacher, nurse) to know? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Thank you for taking the time to complete this form. Please feel free to call the school nurse with any questions or concerns.

**CHERRY HILL  PUBLIC SCHOOLS**

**KINDERGARTEN SESSION REQUEST**

**STUDENT'S NAME:** \_\_\_\_\_

**TODAY'S DATE:** \_\_\_\_\_

**SCHOOL:** \_\_\_\_\_

**Please Circle Your Preference\***

**A.M.      P.M.**

**REASON:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE – PARENT/GUARDIAN**

\*Please be advised that the building principal will make every effort to give you your preference for A.M. or P.M., however no guarantee can be made.