

BERNARDS TOWNSHIP PUBLIC SCHOOLS

HEALTH HISTORY

(To be completed by Parent(s)/Guardian)

Student Name: _____
Last First

Please review the conditions listed below and indicate any that apply with a check (√) Provide further information in the comment section, as to medications for the condition, healthcare provider, last episode, symptoms etc. For all checked items.

√	CONDITION	COMMENTS
	ADD/ADHD	
	Allergies	
	Food	
	Medication	
	Bee Sting	
	Environmental	
	Anaphylactic Reaction	
	Latex	
	Anemia	
	Asthma / Bronchitis	
	Bowel Problem	
	Cancer	
	Chicken Pox	
	Chronic / Recurrent Illness	
	Convulsions/Seizures	
	Diabetes	
	Ear Infections	
	Eating Disorders	
	Emotional / Psychiatric Problems	
	Fainting	
	Fracture / Dislocation / Sprain	
	Frequent colds/sore throat	
	Frequent Headaches	
	Frequent stomach aches	

√	CONDITION	COMMENTS
	Hearing Problem	
	Heart Problem	
	Hepatitis	
	Hypertension	
	Kidney/Urinary Problem	
	Leukemia	
	Lyme Disease	
	Mononucleosis	
	Neuromuscular Disease	
	Orthopedic Problem	
	Operations / Conditions requiring hospitalization	
	Rheumatic Fever	
	Scoliosis	
	Sickle Cell Anemia	
	Skin Condition	
	Speech Communication Problem	
	Strep Infections	
	Sustained illness past 3 months	
	Substance Abuse (alcohol, drugs)	
	Toothache, Dental problem	
	Tumor	
	Vision Problem	

List any other concerns you may have about your child's health, development, learning, behavior or home situation, which might affect their performance _____

Parent/Guardian Signature: _____ Date: ____/____/____

Bernards Township Public Schools**Physical Examination**

(To be completed by Physician)

Student Name: _____ Date of Birth: _____ / _____ / _____

Vaccine Type	MO/ DAY /YR	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR
Diphtheria, Tetanus, Pertussis (Please Specify Type, Td, DT)						
Polio- (Please Indicate)	IPV / OPV	IPV / OPV	IPV / OPV	IPV / OPV	IPV / OPV	IPV / OPV
Measles, Mumps, Rubella - MMR						
Measles				Measles Serology	Date:	Titer:
Rubella				Rubella Serology	Date:	Titer:
Mumps				Mumps Serology	Date:	Titer:
Haemophilus B (HIB)						
Hepatitis B 3 Dose or 2 Dose				Hepatitis Serology	Date:	Titer:
Varivax		Prevnar		Other		
Mantoux TB Test	Date Given: ____/____/____ Date Read: ____/____/____ Result: ____MM					

DATE OF EXAM: ____ / ____ / ____ Ht: _____ Wt: _____ B/P: _____

Allergies: _____ Medications: _____

Significant Medical / Surgical History: _____

Vision (without glasses): Rt.: 20 / _____ Lt.: 20 / _____ Hearing : Rt.: _____ Lt.: _____

	Normal	Abnormal	Comments		Normal	Abnormal	Comments
Ears (otoscopic)				Genito-Urinary			
Eyes				Orthopedic			
Lymph Glands				Structural			
Thyroid				Posture			
Nose				Feet			
Throat				Skin			
Teeth / Mouth				Nutrition			
Heart				Nervous System			
Lungs				Speech			
Abdomen				Other			
Hernia				General			

Any Limitations To: Classroom Activities Yes _____ No _____ Comments _____

Physical Education Yes _____ No _____ Comments _____

Competitive Athletics Yes _____ No _____ Comments _____

Give details of Management of Significant Illnesses: _____

STAMP

(MUST BE PRESENT FOR THIS TO BE VALID)

Examining Practitioner: _____