HEALTH QUESTIONNAIRE

Paramus Public Schools

Parents: Please complete this Health Form

Child's Name _____ Birth Date _____

Parent(s)/Guardian(s) _____ School _____

Question	Yes	No	Explain All "Yes" Answers
Were there any problems during pregnancy and/or birth?			
Do you have any concerns about your child's health (eating, sleeping, teeth, weight, skin, etc.?)			
Has your child ever had any eye problems (difficulty seeing, crossed eyes, squinting, frequently red, water)?			
Has your child ever had an eye exam? Date: Result_____.			
Does your child wear glasses? All day?			
Has your child ever had any ear or hearing problems (frequent earaches, difficulty hearing, tubes in ears)?			
Has your ever had a hearing test? Date? Has your child ever had a hearing evaluation? Date?			
Does your child wear hearing aids?			
Did your child have any delays in motor skills?			
Does your child have any speech problems (difficult to understand, stuttering, slow speech development)?			
Has your child ever had speech therapy? Date?			
Does your child have any other physical problems or impairments which might affect normal academic progress or participation in the usual school program?			
Should there be any restriction of physical activity in school?			
Does your child have any psychological, emotional or behavioral problems which might affect school performance?			
Has your child had any accidents or illnesses serious enough to require hospitalization?			
Has your child had any broken bones?			
Is your child on any daily or long term medication?			
Does your child have any health problem which might require emergency action while he/she is at school (seizures, insect sting allergy, bleeding problem, diabetes, severe asthma, etc)?			
Is there a family history of chronic illness or learning problems?			

HEALTH HISTORY FORM

Paramus Public Schools

Parents: Please complete this Health Form

Child's Name _____

Condition	Yes	No	Date	Explanation
Asthma				
Allergic to drugs				
Allergies – food, environment				
Chicken pox				
Seizure Disorder				
Diabetes				
Ear Infections				
Hearing problems				
Emotional problems				
Heart disease				
Hepatitis				
Kidney disease				
Mononucleosis				
Nosebleeds				
Pneumonia				
Scarlet fever				
Strep infection				
Speech difficulties				
Concussion				
Fractures				
Operations				
Severe injuries				
Other hospitalizations				
Other conditions				
Other injuries				

Is your child taking medications? _____ Name of drug(s) _____

If yes, for what condition(s)? _____

"I give my permission for the school nurse to share all health information with the faculty as needed."

Signature of Parent/Guardian _____Date _____

Nurse's Summary _____

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