LITTLE SILVER SCHOOLS
Little Silver, NJ

Name_____

Health Questionnaire and Developmental History

Does your child have any of the following health conditions now or in the past?

	Yes	No	Explain
Asthma			
Cardiac problems			
Car sickness			
Chronic ear infections			
Chicken pox			
Concussion			
Congenital condition (Specify)			
Diabetes			
Environmental allergies			
Fractured bones			
✯ Wears orthopedic device (splint, etc.)			
Frequent headaches			
Head injury			
Hearing problem			
✯ Wears hearing aid			
Hives			
Lyme disease			
Migraine headaches			
Seizure disorder			
Sinus infections			
Speech problem/concern			
Strep throat			
Urinary/bowel problems			
Vision problem			
✯ Wears glasses or contact lenses (Circle one)			
Other			

1. Does your child have a **life-threatening allergy** (requires an Epipen) to the following:

	Yes	No	If yes, which one(s)?
Foods			
Insects			
Other			

2. Does your child have any other allergies? Yes No
If yes, please specify type of allergy and reaction (hives, etc.):

_____
_____
_____

3. Does your child take any medications either daily or as needed? Yes No
If yes, please list name of medication, reason for use and how often child takes the medication:

_____
_____

(OVER)

4. Has your child had any serious illness, injury or surgery? Yes No
If yes, please give details and date(s) of illness, injury, hospitalization or surgery:
_____
_____

5. **Birth Data** Full-term _____ Premature _____ (weeks)
Birth weight _____ Apgar score (if known) _____
Please indicate any difficulties during pregnancy or birth: _____
_____

6. **Developmental Data**: Please give approximate ages that your child accomplished the following:
Sat up _____ Walked _____ Talked _____
Toilet trained _____
Left or right handed? _____ Established when? _____

7. Check any of the following patterns that you have observed in your child:
Easily frustrated _____ Completes tasks slowly _____
Exhibits aggressive behavior _____ Shyness _____
Talks a lot _____ Temper tantrums _____ Moody _____
Short attention span _____ Overly active _____
Difficulty communicating needs and wants _____
Other (please specify) _____

8. Has your child ever qualified or been enrolled in a specialized program? Please check all that apply:
Early intervention (please specify) _____
Pre-School _____ Speech _____ Second Language _____
Gifted and Talented _____ Other (please specify) _____

9. Has your child ever had an IEP _____ or 504 Plan _____?

10. Has your child ever received any private therapies? If so, please specify:
_____
_____

11. Do you have any concerns about your child's developmental behavior or emotional well-being that the school should be aware of? _____
_____
_____

12. Do you have any other concerns that you would like to share with us? _____
_____
_____

Student Release Authorization:

In the event that the school is unable to contact the parent/guardian, I authorize that my child may be released to the person(s) listed below:

_____ _____
Name and Relationship to Child Home and Cell Phone Numbers

_____ _____
Name and Relationship to Child Home and Cell Phone Numbers

Parent/Guardian Signature _____ Date _____

Sharing of Information:
I acknowledge that the information noted above may be shared with school staff members on a need-to-know basis for the safety and well-being of my child.

Parent/Guardian Signature _____ Date _____

Little Silver Schools
Little Silver, NJ

NEW STUDENT PHYSICIAN'S EXAMINATION FORM

Incoming students must have evidence of a physical examination upon entry into a NJ Public School District. The exam must state what, if any, modifications are required for full participation in the school program. Please return this completed form to the Point Road (or Markham Place if in Grades 5-8) School office by **July 1**.

Child's Name_____ Date of Birth_____

Address _____ Phone: _____

History and date of serious illness, injury, surgery, etc. _____

Does child require any of the following (please check all that apply): glasses _____ hearing aid _____
Corrective shoes _____ other_____

Is child presently taking any prescribed medication? If so, please explain: _____

Physical examination: WT _____ HT _____ BP _____ Heart _____ Lungs _____
Eyes _____ Ears _____ Nose _____ Throat _____ Skin _____
Orthopedic _____ Abdomen _____ Speech _____ Lymph nodes _____
General appearance _____

History (give dates where applicable): Asthma _____ Allergies (type) _____
Chicken Pox _____ Drug allergies _____ Hernia _____
Lyme disease _____ Meningitis _____ Mononucleosis _____Pneumonia_____
Seizure disorder _____ Strep _____Other _____

The following vaccines are REQUIRED. Please supply **month, day, and year.** (A copy of immunization record may be attached)

DPT: (1) _____ (2) _____ (3) _____ (4) _____ (5) _____
(Minimum 4 doses of DPT required-one must be given after age 4)

OPV or IPV (indicate which)**:** (1) _____ (2) _____ (3) _____ (4) _____
(Any 4 doses or 3 doses if one is given after age 4)

MMR (Measles, Mumps, Rubella)**:** _____ _____
(2 doses after age 1) (1) (2)

Hepatitis B: _____ _____ _____
(1) (2) (3)

HIB: (one dose after first birthday) (1) _____ (2) _____ (3) _____ (4) _____

Varicella: (one dose after age 1 or proof of disease immunity) _____

OPTIONAL:

Hepatitis A: (1) _____ (2) _____

Mantoux Tuberculin test: Date: _____ Result: _____

DATE OF EXAMINATION: _____

SIGNATURE OF PHYSICIAN/CNP: _____

PRINTED NAME OF PHYSICIAN/CNP: _____