WANAQUE PUBLIC SCHOOLS

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Health Survey

Date of registration _____ School: ❒ Haskell ❒ Wanaque

To Parents/guardians: The purpose of gathering this data is to assist the school personnel to better serve your child in the educational environment.

Name _____ **Birth Date** _____/____/_____

Significant Health History

Has your child had any of the following?

Asthma _____
Anxiety/Depression _____
Diabetes _____
Ear Infection/Fluid _____Tubes _____
Eczema _____
Glasses _____
Heart disease _____
Heart Murmur _____ Restrictions_____
Intestinal/Stomach problems_____
Kidney/bladder problems _____
Migraines _____
Scarlet fever _____ Rheumatic fever _____
Tuberculosis_____
Whooping cough _____
Other (specify) _____

Has your child had any of the following?

Accidents _____
_____
Hospitalizations _____
_____
Operations_____
_____
Seizures _____
_____
High fevers and/or frequent illnesses _____
_____

Dental Exam _____ (Date) _____ (Braces)
Eye Exam _____ (Date) _____ (Contacts) (Glasses)
Immunizations/Tetanus_____ (Date) _____ (Type)

Does your child have any Allergies?

Peanut _____ Tree nut _____ Bee/Wasp _____ Medicine _____ Seasonal _____ Other _____
Explain _____
Inhaled (breathed) _____ Ingested (eaten) _____ Both _____ Tactile (touched) _____ Unknown_____

Please let us know what reaction your child has if exposed to this allergen: _____
_____

Does your child have any handicapping conditions?

Congenital _____ Vision _____

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Deformities _____ Orthopedic _____
Hearing _____ Birth injury_____ -
over-

What medications (prescribed or over-the-counter) have been or are currently given to your child?

_____

_____

What medical treatment, if any, is your child presently receiving? _____

_____

Physician's name_____ Physician's phone number_____

Has your child seen a psychiatrist or psychologist? Yes _____ No _____ When? _____

Results? _____

In your opinion is your child healthy? Yes _____ No _____

GROWTH AND DEVELOPMENT

Did your child have a normal birth? Yes ___ No ___Explain_____

Does your child have brothers and sisters? _____ Names and ages _____

_____

Did your child have any special growth and development problems in the pre-school years?

_____

Does your child show good coordination? Yes ___ No ___Explain_____

Does anyone have difficulty understanding your child? Yes ___ No___

Does your child understand and respond to directions and questions? Yes ___ No ___Explain_____

Does your child understand and/or speak a language other than English? Yes ___ No ___

If yes, what language _____

Has your child had his/her speech/language/hearing evaluated? Yes ___ No ___ Which _____

When? _____ Results? _____

Does your child have any of the following?

Bedwetting _____	Poor eating habits _____	Temper tantrums _____
Disturbed sleeping patterns_____	Nervous tendencies _____	Cries easily _____
Special fears/ nightmares _____	Sensitive _____	Finger sucking _____
Over active _____	Problems with Potty Training _____	Rocking pattern _____
Nail biting _____	Other _____	

Please comment on those conditions that pertain to your child _____

_____

Is there any other information that would be helpful in planning for your child's school experience?

_____

_____

Date _____ Parent's Signature _____