

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) _____

Dental Exam _____
Date _____

Eye Exam _____
Date _____

Immunizations/Tetanus _____
Date _____

Has your child had any of the following?

Accidents _____

Hospitalizations _____

Operations _____

Seizures _____

High fevers and/or frequent illnesses _____

Braces _____

Contacts _____ Glasses _____

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 _____
Deformities _____
Hearing _____
over-

Vision _____
Orthopedic _____
Birth injury _____

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 _____