Hopewell Valley Regional School District

Division of Pupil Services
425 South Main Street
Pennington, NJ 08534

CONFIDENTIAL HEALTH HISTORY

(to be completed by parent or guardian)

I. Identifying Information

Child's Last Name _____ First _____ Middle _____ Gender _____ Birth date (month/day/year) _____

Address (Number – Street, City and Zip) _____

Parent/Guardian Name _____ Home phone / business phone _____

Parent/Guardian Name _____ Home phone / business phone _____

Child lives with: _____

II. Pregnancy and Birth History

A. Pregnancy

1. Illness of mother during pregnancy YES NO
2. Injury of mother during pregnancy YES NO

B. Birth History

1. Premature YES NO
2. Long labor YES NO
3. Instrument delivery YES NO
4. C-section YES NO
5. Birth weight: _____
6. Oxygen given during birth YES NO
7. Incubator used YES NO
8. Bili lights used YES NO
9. Illness of baby during first 28 days? YES NO

If your response has been YES to any of the above items, please specify the nature of the problem in the space below.

_____

_____

III. Previous Exams

A. What is the date of your child's last physical exam? _____

B. What is the date of your child's last dental exam? _____

C. What is the date of your child's last eye exam? _____

Has your child ever been treated for a visual disorder? YES NO If yes, please explain:

_____

_____

Has your child been prescribed glasses or contact lenses? YES NO If yes, please explain:

_____

_____

IV. Mental, Emotional and Social Health History

A. Has your child been treated for emotional issues? YES NO

B. Has your child been treated for behavioral difficulties? YES NO

C. Briefly describe your child's play habits alone and with peers/siblings. _____

_____

V. Medical History

A. Has your child had problems in any of the following areas? Please check **YES** or **NO**.

Yes	No		Yes	No		Yes	No		Yes	No	
		Cancer			Eyes			Arthritis			Headaches
		Diabetes			Ears			Joint pain			Blackouts
		Down's syndrome			Nose			Growth problems			Dizziness
		High blood pressure			Throat			Hives			Fainting spells
		Seizure disorder			Jaws / teeth			Skin disorders			Ringing in ears
		Frequent nose bleeds			Wrists			Fungus infections			Lungs
		Tuberculosis			Hands			Nervous disorders			Shortness of breath
		Heart (rheumatic fever, etc.)			Fingers			Hernia (rupture)			Wheezing
		Stomach (ulcer, etc.)			Leg			Diabetes			Persistent cough
		Neuro-muscular condition			Hip			Epilepsy (convulsions)			Asthma
		Liver (hepatitis, etc.)			Knee			Blood in urine			Hay fever
		Enuresis (bed wetting)			Ankle			Diarrhea			Mononucleosis
		Bladder problem			Back / spine			Orthopedic problem			Chicken pox
		Fatigue & undue tiredness			Foot			Genitalia issues			Lyme disease
		Eating disorder			Toes			Autism			Tourette syndrome
		Head injury									

If you answered **YES** to any of the conditions listed above, please explain in the space below. Give the date and outcome of all conditions above or any conditions or medical history not listed. You may attach additional sheets and medical records if necessary.

_____

_____

B. Has your child ever received speech therapy? YES NO If yes, please explain:

_____

_____

C. Has your child ever been treated for a hearing disorder? YES NO If yes, please explain:

Does your child have a hearing aid? YES NO

_____

_____

D. Does your child have any eating problems or special diets? YES NO If yes, please explain:

_____

_____

E. Does your child have any condition which might limit his/her activities at school? YES NO If yes, please explain:

_____

_____

F. What medication does your child take daily? _____

G. What medications are given frequently, but not daily? _____

H. Allergies: Please list and describe any allergies and the reactions:

Medication: _____

Food: _____

Plants / animals / latex / bee sting / other: _____

I. Please list any surgeries, hospital admissions (medical or psychiatric), serious diseases, accidents or emergency room visits:

_____

_____

VI. Family History

Please circle and indicate relationship:

Diabetes	_____	Asthma	_____
Cancer	_____	Epilepsy	_____
Kidney disease	_____	Speech disorder	_____
High blood pressure	_____	Vision disorder	_____
Heart disease	_____	Hearing disorder	_____
Allergies	_____	Nervous/emotional disorder	_____

VII. Comments / Concerns

If you have any other comments or concerns about your child's health, development, behavior, family or home life that you would like the school to be aware of, please explain.

_____

_____

_____

_____ _____

Signature of Parent / Guardian Date