WESTFIELD PUBLIC SCHOOLS, Westfield, New Jersey

HEALTH HISTORY

TO BE COMPLETED BY PARENT OR GUARDIAN AND PRESENTED TO NURSE AT TIME OF REGISTRATION

LAST NAME	FIRST NAME	INITIAL	BIRTHDATE	BIRTH PLACE	GENDER

ADDRESS	PHONE	EMAIL

FATHER	MOTHER

PERSONAL HEALTH HISTORY

Birth weight _____ lbs. _____ oz.

	Yes	No
Illness of mother during pregnancy	☐	☐
Born prematurely	☐	☐
Complications of delivery	☐	☐
Difficulty soon after birth	☐	☐

Specify: _____

Walked alone when _____ months old

Said a few words when _____ months old

Family Health History

Relation	Year of Birth	State of health
Father		
Mother		
Siblings		

Has your child had any of the following?	Yes	No	Date
Allergies	☐	☐	
Asthma	☐	☐	
Anxiety	☐	☐	
Bronchitis	☐	☐	
Chicken Pox	☐	☐	
Convulsions or other seizures	☐	☐	
Difficulty with toilet, training or bedwetting	☐	☐	
Fainting with or without activity	☐	☐	
Frequent diarrhea or constipation	☐	☐	
Frequent ear infections	☐	☐	
Frequent nose bleeds	☐	☐	
Frequent sore throats	☐	☐	
Frequent vomiting	☐	☐	
Heart murmur	☐	☐	
Nightmares or trouble sleeping	☐	☐	
Pneumonia	☐	☐	
Rheumatic Fever	☐	☐	
Severe injury	☐	☐	
Shortness of breath with or without activity	☐	☐	
Surgery	☐	☐	
Tendency to bleed easily when cut	☐	☐	
Trouble with hearing	☐	☐	
Trouble with speech	☐	☐	
Trouble with vision	☐	☐	

Has any relation had:	Yes	No
Cancer	☐	☐
Convulsive disorder	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Mental Illness	☐	☐
Significant Allergy`	☐	☐
Tuberculosis	☐	☐

Add any additional information and explanation for any checked "yes":

_____

_____

_____

_____

_____

_____

_____

Parent Signature Date