MontvilleTownshipPublicSchools

HealthServices

STUDENTHEALTHQUESTIONAIRE

Name: _____

CHILDHOOD DISEASES

A. Has your child had the following diseases? (Include dates)
   1. Asthma_____
   2. Chicken Pox _____
   3. Diabetes_____
   4. German Measles (3 day Measles) _____
   5. Heart Murmur _____
   6. High Fever _____
   7. Measles (Rubella) _____
   8. Meningitis _____
   9. Mumps_____
   10. Pneumonia_____
   11. Rheumatic Fever_____
   12. Scarlet Fever_____
   13. Seizures_____
   14. Strep Throat _____

B. Has your child had other serious illnesses for which he/she was not hospitalized? Describe:

☐ No ☐ Yes

C. Has your child ever been hospitalized – Please include dates, diagnosis and treatment.

☐ No ☐ Yes

ALLERGIES

A. Does your child have the following:
   1. Food allergy – describe: _____
   2. Medication allergy – describe: _____
   3. Severe reaction to insect bite: ☐ No ☐ Yes

EARS, NOSE, THROAT, EYES

A. Does the child have myringotomy tubes in his/her ears? ☐ No ☐ Yes
B. Does your child have frequent nosebleeds? ☐ No ☐ Yes
C. Do you have concerns about your child's hearing or vision? ☐ No ☐ Yes
   Describe:

D. Does your child wear glasses? ☐ No ☐ Yes

SPECIAL CONCERNS

A. Does your child take any medications regularly? ☐ No ☐ Yes
   Describe:

B. Does your child have any physical limitations? ☐ No ☐ Yes
   Describe:

C. Do you have any concerns about your child? ☐ No ☐ Yes
   Describe:

As a parent/guardian of the above named student, I hereby authorize the release of pertinent information medical information (i.e. Conditions, allergies and treatment regimens) to be exchanged among appropriate professional staff involved in the care of the above named student. This consent is valid in the Montville Township School District and is intended to allow the staff to better serve my child.

Signature of Parent/Guardian: _____

Date: _____