# River Edge Public Schools

410 Bogert Road, River Edge, New Jersey 07661
201-261-3404 Fax 201-261-0698
www.riveredgeschools.org

# Health History Form

**Demographics**

Child's Name: _____ Birth Gender: M _____ F _____

Phone #: _____ Place of Birth: _____ Birth Date: _____

Primary Language: _____ Secondary Language: _____

Address: _____

Parent/Guardian Name: _____ Parent/Guardian Name: _____
Relationship to Child: _____ Relationship to Child: _____

Siblings: Name: _____ Age: _____ Grade: _____
Name: _____ Age: _____ Grade: _____
Name: _____ Age: _____ Grade: _____

Child's Physician Name: _____ Phone #: _____
Hospital Preference: _____
Dentist's Name: _____ Phone #: _____

**Developmental History**

Did you notice any delay or abnormal behavior in your child's early growth years? Yes ____ No _____

_____

_____

**Medical History of Child**

Any history of head injuries, head trauma, or any diseases of the Brain? Yes ____ No ____
If yes, explain:

_____

Any Hospitalizations for an Operation, Accident, or Medical Illness? Yes ____ No ____
If yes, explain: _____
Allergies:

Food: _____
Type of Reaction: _____ Last Occurrence: _____

Medication: _____
Type of Reaction: _____

# Health History Form (Page 2)

Pollen/Seasonal Allergies? Yes ____No ____ Type of reaction: _____

Bee Sting Allergy? Yes ____ No ____ Reaction: _____

Allergic to Animals? Yes ____ No ____ Reaction: _____

Other Allergies? _____

History of Illnesses: Check all that apply:
ASTHMA ____ BRONCHITIS ____ CANCER ____ EAR INFECTION ____ EAR TUBES ____
DIABETES ____ ECZEMA____ SKIN DISORDERS ____ SEIZURES/CONVULSIONS ____ HEART DISEASE ____

OTHERS: _____

Is your child on any medications? Yes ___ No ____

Medication: _____ Reason: _____
Medication: _____ Reason: _____

Does your child wear glasses or contact lens? Yes ____ No ____ (circle glasses or contact lens)

Any problems with:

SPEECH VISION HEARING PHYSICAL LIMITATIONS

Explain: _____

ADDITIONAL COMMENTS OR CONCERNS ABOUT YOUR CHILD:
_____

**Signature/Release of Information:**

As Parent/Guardian of _____, I hereby authorize the release of pertinent medical information about my child to those professional staff involved in his/her care or instruction. This consent is valid in the River Edge Public School District and may be revoked by myself at any time in writing.

_____ _____ _____
SIGNATURE PRINT NAME DATE

Form Updated: 7/21/2021