Winslow Township School District

Student Health History **Date:_____**

Student Name: _____ Date of Birth: _____ Sex: ____

Address:_____ Phone: _____

To the best of your knowledge, does your child have any problems which may affect his/her learning in school, cause you any concern, and/or may be important for the school staff to know? Please circle "yes" or "no" for each of the following questions and explain all "yes" answers.

1. Has your child ever had any serious illnesses, operations, or a heart murmur? Yes No
   If yes, please give dates and explain _____
2. Does your child have any eye problems (difficulty seeing, crossed eyes, frequent reddened or watery eyes, wear glasses or contact lenses) Explain _____ Yes No
3. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, fluid in ear, drainage, or use a hearing aide) Explain_____ Yes No
4. Has your child had tubes placed in ears? Date_____ Yes No
5. Does your child have any speech problems (difficult having speech understood, stammering, delayed speech development, stuttering) Explain _____ Yes No
6. Does your child have any allergies? Yes No
   Food type: _____Symptoms:_____ Last Reaction:_____
   Insects/Bees:_____ Symptoms:_____ Last Reaction:_____
   Drugs:_____ Symptoms:_____ Last Reaction:_____
   Treatment for any above allergies: _____
7. Do you have any concerns about your child's general health, eating and sleeping habits, bowel or bladder, posture, teeth, skin, growth, etc.? Yes No Explain _____
   _____
8. Other health conditions: (please circle those that apply and list the year of onset).
   chicken pox _____ high fevers_____ diabetes_____ seizures/convulsions_____
   sickle cell disease_____ headaches _____nosebleeds _____toothaches_____
   sore throat/infections _____ other_____
9. Does your child have any medical condition or problem which might, in your opinion, affect their school performance or program. Explain_____ Yes No
10. Does your child require any special health care in school? Yes No
    Explain _____
11. Does your child require medication at home or at school? Yes No
    Explain _____
12. Do you have any concerns about your child's developmental behavior or emotional well-being that the school should know about? Yes No
    Explain_____
13. Does your child have asthma? Yes No
    If yes, triggers _____ symptoms_____treatment_____

Any further remarks_____
_____
_____

WTSD Board of Education
Approved 12/18/07