MAYWOOD PUBLIC SCHOOLS
PHYSICAL EXAMINATION

Part A: HEALTH HISTORY QUESTIONNAIRE – Completed by parent and reviewed by examining provider
Part B: PHYSICAL EXAMINATION FORM – Completed by examining licensed provider

Part A: HEALTH HISTORY QUESTIONNAIRE **School Year _____**

Student's Name: _____ Gender (circle) Male / Female Age:_____ Grade:_____

Date of Birth: _____ Place of Birth: _____

Mother/Guardian's Name: _____ Phone:_____

Father/Guardian's Name: _____ Phone:_____

Address: _____

Child's Physician: _____ Phone: _____

Previous School (if applicable): _____ Phone:_____

Previous School Address: _____

Part I – Student Health Status

Complete the following checklist by indicating any of the following conditions, past or present. Include a separate sheet if additional detail is necessary.

	NO	YES	YEAR
Activity restrictions			
ADD/ ADHD			
Allergies			
Anemia (include sickle cell)			
Arthritis			
Asthma			
Autism Spectrum Disorders			
Auto Immune Disorder			
Back / Neck injury			
Behavior Problems			
Blood / Clotting Disorder			
Cancer / Leukemia			
Chest pain / palpitations			
Chicken Pox			
Congenital Disorder			
Developmental Delays			
Diabetes			
Diet Restrictions			
Drug Allergies			
Epilepsy			
Fainting			
Fatigue or undue tiredness			
Fractures / Dislocations			
Others			

	NO	YES	YEAR
Head Injury			
Headaches			
Heart Disease			
Hematological Disorders			
Hearing deficit			
Hepatitis			
Hospitalization/ Surgery			
Lyme Disease			
Mononucleosis			
Neuromuscular Disorder			
Otitis Media			
Physical Disability			
Rheumatic Fever			
Seizures			
Skin conditions			
Speech / Language			
Strep Infections			
Tuberculosis			
Urinary problems			
Vision deficit: Wears Glasses/ Contacts			
Others			

Please give details for all that are marked YES above: _____

_____

Any other information related to your child's health: _____

_____

If your child has allergies?

- ❑ Mild
- ❑ Moderate
- ❑ Severe

Nature of allergy:_____

Type of reaction: _____

EPIPEN prescribed? NO _____ YES _____ YEAR _____

If your child has asthma?

- ❑ Mild
- ❑ Moderate
- ❑ Severe

Medications taken: _____

If your child has diabetes? Insulin, glucometer and care needed at school _____

If your child has seizures? Describe type and medications taken: _____

Part II – Current Medication

Is your child taking any medication (prescribed and/or OTC)? NO _____ YES _____

Medication	Dosage	Frequency	Reason

Is medication required during school hours? NO _____ YES _____

*** If <u>YES</u>, obtain the necessary form from the school nurse. Your child's physician must complete & sign the form.**

Part III – Health Insurance

Does your child have Health Insurance?

NO _____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online.

YES _____ If Yes, name of insurance company _____.

Part IV – Consent and Signature

The School Nurse has permission to contact my child's doctor if medically necessary.

I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact their learning.

I understand that medications of any kind are not allowed on school grounds without the proper medical authorization on file. I understand that school staff including the nurse MAY NOT administer or assist with any medications without the proper medical authorization on file.

I understand that for the safety of my child, or to provide for their educational program, the school nurse may need to share information about my child's condition with appropriate school staff. This will be done in a confidential manner. If you do not wish that information be shared, I must request this in writing and file it with the school nurse.

_____ _____

Parent / Guardian Signature **Date**