

Clifton Public Schools
Clifton, NJ

STUDENT HEALTH INVENTORY

Name _____ Grade _____
Last First
Sex _____ Birth date _____ School _____

Parent's Names: Father _____

Mother _____

Student's Medical Doctor _____

Is your child under the care of an orthodontist? Yes ___ No ___ If yes,

Orthodontist's Name _____

DOES YOUR CHILD HAVE:

1. Allergies: Yes ___ No ___ If yes, to what _____
2. Does he/ she takes medication routinely? Yes ___ No ___ If yes, what Medication _____
3. Asthma: Yes ___ No ___ Medication used _____
4. Diabetes: Yes ___ No ___ Take insulin? _____ How often? _____
5. Frequent ear infections: Yes ___ No ___ Explain _____
6. Frequent sore throats: Yes ___ No ___ Explain _____
7. Frequent headaches: Yes ___ No ___ Explain _____
8. Epilepsy or convulsions: Yes ___ No ___ Explain _____
9. Heart murmur / condition: Yes ___ No ___ Explain _____
10. Orthopedic problem: Yes ___ No ___ Explain _____
11. Muscular problem: Yes ___ No ___ Explain _____
12. Drug sensitivities: Yes ___ No ___ Explain _____
13. Congenital Defects: Yes ___ No ___ Explain _____

HAS YOUR CHILD HAD :

1. Chicken pox Yes ___ No ___ Date _____
2. Measles Yes ___ No ___ Date _____
3. Mumps Yes ___ No ___ Date _____
4. German measles Yes ___ No ___ Date _____
5. Bronchitis Yes ___ No ___ Date _____
6. Pneumonia Yes ___ No ___ Date _____

- 7. Tuberculosis Yes____ No____ Date_____
- 8. Rheumatic Fever Yes____ No____ Date_____
- 9. Mononucleosis Yes____ No____ Date_____
- 10. Hepatitis Yes____ No____ Date_____
- 11. Serious illness Yes____ No____ Date_____

Explain_____
- 12. Serious injury Yes____ No____ Date_____

Explain_____
- 13. Operations Yes____ No____ Date_____

Explain_____

DOES YOUR CHILD:

- Wear glasses ? Yes____ No____
- Have contact lenses ? Yes____ No____
- Have trouble seeing close work? Yes____ No____
- Have trouble seeing at a distance? Yes____ No____
- Have trouble hearing? Yes____ No____
- Wear a hearing aid ? Yes____ No____
- Have difficulty with speech? Yes____ No____
- Have tendency to bleed easily ? Yes____ No____
- Have frequent nosebleeds ? Yes____ No____
- Have frequent vomiting or diarrhea? Yes____ No____
- Occasionally wet his/ her pants? Yes____ No____
- Occasionally have bowel movements

in his/ her pants ? Yes____ No____
- Take daily medication ? Yes____ No____

What for?_____
- Take emergency medication ? Yes____ No____

What for?_____
- Have a condition, which prevents participation in regular physical education activities?

Yes____ No____

Explain_____

Any other Health Problems of which we should be aware? Yes____ No____

Explain_____

Parent's Signature_____Date_____

PLEASE NOTIFY THE SCHOOL NURSE of any medical problems, serious illnesses, or communicable diseases that arise while the student is enrolled at this school.

PLEASE NOTIFY THE SCHOOL NURSE of any immunizations received by your child.

09/07