

North Haledon School District

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Health Assessment and Documentation for School Nurse

Child's Name: _____ Nickname: _____

Address: _____ Date of Birth: _____

_____ Telephone #: _____

Does your child have Health Insurance?

Yes If yes, name of insurance company _____

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 njfamilycare.org to apply online.

You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Yes No

Signature: _____ Printed Name: _____ Date: _____

Written consent required pursuant to 20 U.S.C. § 1232g (b)(1) and 34 C.F.R. 99.30 (b).

1. Were there any complications during birth? _____

2. How do you feel your child's health is now?

Excellent _____ Good _____ Poor _____

3. Does your child see a doctor, dentist, psychologist, physical or speech therapist regularly?

Yes _____ No _____

If yes, how often _____ and for what conditions? _____

4. Does your child take medication regularly? _____

If so, for what reason? _____

5. Has your child had any serious illness, accident, operations, sutures or fractures? Please describe and

give dates: _____

6. Does your child have frequent colds? _____

7. Has your child ever had:

___ Measles
___ Mumps
___ German Measles
___ Epilepsy
___ Pneumonia

___ Scarlet Fever
___ Rashes
___ Strep Throat
___ Chicken Pox
___ Headache

___ Ear Infections
___ Bronchitis
___ Tonsillitis
___ Asthma
___ Cardiac

8. Does your child have any allergies?

___ medicine? ___ foods? ___ dust or pollen? ___ insects?

9. At what age did your child: ___ sit? ___ crawl? ___ stand? ___ walk?

___ speak words? ___ sentences?

10. ___ Left Handed ___ Right Handed

11. Have you had any concerns about your child's growth and development? ___ yes ___ no

12. Does your child have any problem with:

___ hearing ___ vision ___ speech

13. Does he/she wear glasses? ___ hearing aid? ___

14. Your child's appetite is: ___ excellent ___ good ___ fair ___ poor

Is he/she on a special diet at home? _____

15. Does your child sleep well at night? _____

16. Does he/she have a rest period during the day? _____

17. Does your child: suck his thumb ___ bite nails ___ wet the bed ___

18. Is your child able to dress him/herself? _____

19. Is he/she able to take care of his/her bathroom needs? _____

20. Place a check on the line between the word which best describe your child:

Happy	___	___	___	___	___	___	Sad
Outgoing	___	___	___	___	___	___	Shy
Easy Going	___	___	___	___	___	___	Nervous
Mature	___	___	___	___	___	___	Immature
Separates easily from parents	___	___	___	___	___	___	Does not
Plays well with others	___	___	___	___	___	___	Plays alone

21. Has your child attended nursery/preschool? _____ Number of years _____

22. Other care givers besides parents _____

23. Has your child ever experienced a severe emotional shock? (ie: auto accident, death, divorce or other upsetting situations) _____

If yes, please explain: _____

24. Does your child have any strong fears? (dark, thunderstorms, dogs, masks, clowns etc.)

Is there any other information that you wish to share with us?

Thank you for your cooperation in completing this form. It will make your child's kindergarten experience a more fulfilling one.

Parent/Guardian signature _____ Date _____