CARLSTADT PUBLIC SCHOOL
CARLSTADT, NEW JERSEY 07072

STUDENT HEALTH HISTORY

Dear Parents/Guardians:

In order to keep our student health records current, we are asking you to please complete the following health history for your child. It is very important that we have this information to better care for your child's health.

I give my permission to share this information with appropriate school staff.

_____☐_____Yes _____☐_____ No

Ruth Polifronio, R.N.

School Nurse

STUDENT'S NAME_____**Grade**_____

Student's Date of Birth_____ **Age:**_____ **Gender: M**__☐__ **F**__☐__**(check one)**

	IF YES, PLEASE INDICATE DATE	TREATMENT & or RESTRICTIONS RECOMMENDED BY PHYSICIAN
ALLERGIES		
ASTHMA		
CHICKEN POX		
CONGENITAL PROBLEMS		
CONVULSIONS		
DIABETES		
HEART AILMENTS (specify)		
HOSPITAL STAYS (specify)		
RASH (specify)		
TENDENCY TO BLEED (spicify)		
URINARY PROBLEMS		
OTHER (specify any physical limitations and restrictions		

Is your child presently taking a prescription medication? _____☐_____YES _____☐_____NO

If yes, please indicate name of medication, dosage, time of day given and reason for use.

SIGNATURE OF PARENT/GUARDIAN_____ DATE:_____