ISLAND HEIGHTS SCHOOL DISTRICT
Health Office-New Entrant Questionnaire
Only the natural parent or guardian may register a student.

Student Name:_____ DOB:_____Date_____
Birthplace:_____ Age:_____ Sex:_____Grade:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS AND EXPLAIN. ANY "YES" ANSWERS IN THE SPACES PROVIDED

MEDICATIONS: Taken Daily? ▢ **YES** ▢ **NO** **If YES**, List names and doses:

_____

_____

Medication required during school hours? ▢ **YES** ▢ **NO** If YES, Please see Nurse for instructions.
Doctors' orders must be provided for administering and self administering medication (prescription and OTC).

ALLERGIES: Life threatening? ▢ **YES** ▢ **NO** Medication Required? ▢ **YES** ▢ **NO**
If YES, Please see Nurse for Instructions
Medication type: ▢ **EpiPen** ▢ **Benadryl** ▢**Other**_____

ALLERGY TYPE: ▢ **Insect Sting/Bite** ▢ **Food** ▢ **Medication** ▢ **Seasonal** ▢ **Other Specify Allergy Name/Type of reaction:**
_____/_____
_____/_____
_____/_____
_____/_____

ASTHMA: ▢ **YES** ▢ **NO** ▢ **SEASONAL** ▢ **WEATHER RELATED** ▢ **ILLNESS RELATED**

Known triggers: _____

Frequency of attacks (estimated):
▢ **REGULARLY (1-2x a week)** ▢ **Occasionally (1-2x a month)** ▢ **RARELY (1-2x a year)**

Current Daily Asthma Medications:_____
**See Nurse if Medication will be required to be kept in school*

HEART DISEASE: ▢ **YES** ▢ **NO** **Heart Murmur:** ▢ **YES** ▢ **NO** **Diagnosed by a Doctor?** ▢ **YES** ▢ **NO**
Specify type of condition: _____

PLEASE NOTE: *Child will not be permitted to participate in Gym, Health or Recess without a Cardiac Clearance Note from Physician. See Nurse for further instructions.*

DIABETES: ▢ **YES** ▢ **NO** **If YES,** *we will discuss and formulate a care plan for the school year*.

SEIZURE DISORDER: ▢ **YES** ▢ **NO** **FEBRILE EPISODES** ▢ **OTHER Diagnosed by a Doctor?** ▢ **YES** ▢ **NO**
Specify _____

***If YES**, we will discuss and formulate a care plan for the school year.*
Medications / Limitations: _____
Date of Last Seizure: _____ Type: _____
Other Neurological Disorder: ▢ YES ▢ NO Diagnosed by a Doctor? ▢ YES ▢ NO
Specify type of condition:_____

KIDNEY DISEASE: ▢ **YES** ▢ **NO** Specify type of condition: _____

LYME Disease: ▢ **YES** ▢ **NO If YES, Diagnosis Date**_____
Medications/Limitations_____/_____

EYES: ▢ **GLASSES** ▢ **CONTACTS** ▢ **BOTH** ▢ **ALL THE TIME** ▢ **AS NEEDED**
Disorder (Specify): _____ Last eye exam_____

NOSE: ▢ NOSE BLEEDS ▢ NASAL DISCHARGE ▢ SINUS INFECTIONS ▢ FREQUENT ▢ OCCASIONAL

EARS: HEARING DIFFICULTIES ▢ **YES** ▢ **NO** **If YES**: **HEARING AID** ▢ YES ▢ **NO**

AUDITORY PROCESSING DISORDER ▢ YES ▢ NO

FREQUENT EAR INFECTIONS ▢ YES ▢ NO If YES, how many and what age(s)?_____

MOUTH / THROAT: ▢ DENTAL CAVITIES ▢ FREQUENT STREP INFECTIONS ▢ ENLARGED TONSILS
Other concerns: _____

Date of Last Dentist Visit: _____

History of any of the following *(check all that apply, give dates and explain below):*
▢ HEAD INJURIES ▢ BROKEN BONES ▢ HOSPITALIZATIONS ▢ SURGERIES
_____/_____

_____/_____

Please check any of the following *diagnosed or under evaluation by a physician*. Supporting medical documentation MUST be provided.
▢ AUTISM / ASD / Asperger's Syndrome ▢ ADD / ADHD ▢ Anxiety Disorder / OCD
▢ Disruptive Behavioral Disorder ▢ Dissociative Disorder
▢ BEHAVIORAL / EMOTIONAL DISORDER ▢ Pervasive Developmental Disorder
▢ MOOD DISORDER

LEARNING DISORDER: ▢ Dyslexia ▢ Dyscalculia ▢ Dysgraphia ▢ Oral / Written Language Disorder

Non-Verbal Learning Disabilities ▢ Dyspraxia ▢ Executive Function ▢ Apraxia ▢ Speech Disorder
Other Learning Disorder: _____

Please list any other disabilities, limitations or health concerns not already addressed or check ▢ N/A:

_____

_____

Signature:_____ Date:_____

Health Insurance Information:

Does this child have any health insurance, including NJ Family Care / Medicaid, Medicare, private or other?

▢ YES

Name of Insurance Company_____

▢ NO, but you may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature:_____ Date: _____

Printed Name:_____

*Written consent required pursuant to 20 U.S.C. & 1232g (b)(1) and 34 C.F.R. 99.30 (b) *NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information, call 1-800-701-0710 or visit www.njfamilycare.org to apply online.*