



**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:

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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:

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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](http://www.njfamilycare.org) to apply online.*