TOMS RIVER REGIONAL SCHOOLS

Health Office-New Entrance Questionnaire

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** ▢

_____________________________/_______________________________
_____________________________/_______________________________
_____________________________/_______________________________

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

Known triggers: ____

Frequency of attacks (estimated):

__________ **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:

HEALTH OFFICE NEW ENTRANT QUE

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)		
Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.		
Signature/Date	This form may be released to WIC. ☐Yes ☐No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER		
Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No	
Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	
IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:	

MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care ☐Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐	Comments

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the