

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

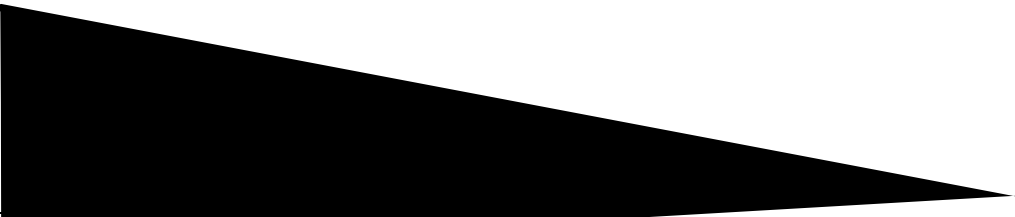
MEDICATIONS: Taken Daily? YES NO If YES, List names and doses: _____

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination:	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due:		
MEDICAL CONDITIONS			
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments	
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments	
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments	
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments	
Allergies/Sensitivities • List allergies:	<input type="checkbox"/>		

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

