Shrewsbury Borough School

20 Obre Place
Shrewsbury. New Jersey 07702

Telephone: (732) 747-0882
Fax: (732) 747-7510

HEALTH RECORD FORM

This Page Is To Be Completed By Parent/Guardian

Student Name:_________________________________ **Date of Birth:**______________

Please circle either: Yes or No

Is your child subject to:

Frequent Colds	Yes	No	Emotional Problems	Yes	No
Frequent Sore Throat	Yes	No	Eating Disorder	Yes	No
Speech Difficulties	Yes	No	Seasonal Allergies	Yes	No
Ear Infections	Yes	No	Sinus Infection	Yes	No
Chronic Cough	Yes	No	Frequent Headaches	Yes	No
Nose Bleeds	Yes	No			

Please list any allergies (Food, Insect, Etc.)____

Please supply date(s) if your child has had any of the following:

Asthma_____________________
Bronchitis___________________
Chicken Pox_________________
Diabetes____________________
Epilepsy/Seizures ____________
Head Injury/Concussion_______
Heart Disease________________
Hernia______________________
High Fevers_________________

Lyme Disease_______________
Mononucleosis______________
Orthopedic Problems__________
Pneumonia__________________
Skin Disorder _______________
Strep/Scarlet Fever___________
Tonsillitis__________________
Tuberculosis________________
Whooping Cough_____________

Has your child had any serious illness, hospitalizations or surgeries? Yes No
If **yes**, please list them ____
____

Is your child taking any medication on a regular basis? Yes No
If **yes**, please list the medication and condition ____________________________________
____

Is your child restricted from physical activity: Yes No
If **yes**, describe restriction: :____
____

Does your child wear glasses, contact lenses, hearing aids, or other appliances? Yes No
If so, please indicate what type:____

_______________________________ _____________________ _____________
Signature of Person Completing Form Relationship to Student Date

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MEDICAL EXAMINATION FORM

TO BE COMPLETED BY HEALTH CARE PROVIDER

Physical Examination Date_________________________ Date of Birth ___________________________

Child's Name____

Home Address____

Home Phone ________________________________ Cell Phone __________________________________

To Be Completed by Physician:

Height:_____________________Weight: _____________________ B.P. _____________________________

Vision Screening______________________________ Hearing Screening_____________________________

Eyes _________ Ears _________ Nose _________ Throat _________

Skin _________ Lungs _________ Heart _________ Chest _________

Spine _________ Abdomen _________ Hernia _________ Lymph Nodes _________

Speech ________ Orthopedic _________ General Appearance ___________________

Asthma ________ Seizures ___________ Tuberculosis ________ Diabetes _____________

Chronic Medical Conditions/Communicable Diseases____

Behavioral/Mental/Emotional Diagnosis ____

Developmental ____

List any allergies ____

List any medications/treatments ____

List any serious illnesses, injuries, hospitalizations, or surgeries _________________________________

____

List any activity restrictions ____

Any additional Comments ____

____

Immunizations - Attach a copy of all Immunizations

____

Physician's Signature/Date

Health Care Provider Stamp