



Health History Questionnaire

Student Name	Date
Has the student had or currently have:	Circle One
A sports physical for this school year?	YES – NO – Don't Know
An injury or illness since his/her last physical exam?	YES – NO – Don't Know
A chronic or ongoing illness (such as diabetes or asthma)?	YES – NO – Don't Know
Use an inhaler or other prescription medicine to control asthma?	YES – NO – Don't Know
Take any prescribed or over-the-counter medications regularly?	YES – NO – Don't Know
Surgery, hospitalization, or any emergency room visits?	YES – NO – Don't Know
Any allergies to medicine?	YES – NO – Don't Know
Any allergies to bee stings, pollen, or skin conditions?	YES – NO – Don't Know
Type of reaction: rash, hives, or skin conditions?	YES – NO – Don't Know
Medication/epi-pen taken for allergy symptoms? (list below)	YES – NO – Don't Know
Any anemias or blood disorders?	YES – NO – Don't Know
Has the student had or currently have any of the following <u>head-related</u> conditions since their last physical?	
Concussion requiring a physician's evaluation?	YES – NO – Don't Know
How often and when? (answer below)	
Memory loss or been knocked out?	YES – NO – Don't Know
A seizure?	YES – NO – Don't Know
Frequent or severe headaches?	YES – NO – Don't Know
Has the student had or currently have any of the following <u>heart related</u> conditions since your last physical?	
Chest pain during physical activity?	YES – NO – Don't Know
Heart murmur?	YES – NO – Don't Know
High blood pressure or elevated cholesterol level?	YES – NO – Don't Know
Restrictions from sports for heart problems	YES – NO – Don't Know
Has any family member or relative:	
Died of a heart problem before age 35?	YES – NO – Don't Know
Died of a heart problem before age 50?	YES – NO – Don't Know
Died with no known reason?	YES – NO – Don't Know
Died while exercising? During or after?	YES – NO – Don't Know
Have or had Marfan's syndrome?	YES – NO – Don't Know

Please explain all "YES" answers here and be sure to include dates where possible:

Circle One

Has the student had or currently have any of the following eye, ear, nose, mouth or throat conditions since last physical?

Vision problems? Wear glasses, contact lenses, or protective eyewear? [circle type]	YES – NO – Don't Know
Hearing loss or problems? Wear hearing aides or implants?	YES – NO – Don't Know
Nasal fractures or frequent nose bleeds? Wear braces, retainer or protective mouth gear?	YES – NO – Don't Know
Frequent strep or any other conditions of the throat? (e.g. tonsillitis)	YES – NO – Don't Know

Has the student had or currently have any of the following neuromuscular/orthopedic conditions since last physical?

Been told he/she had a burner, stinger, or pinched nerve?	YES – NO – Don't Know
A sprain?	YES – NO – Don't Know
A strain?	YES – NO – Don't Know
Swelling or pain in muscles, tendons, bones, or joints?	YES – NO – Don't Know
Dislocated joint(s)?	YES – NO – Don't Know
Lower back pain?	YES – NO – Don't Know
Fracture(s) or stress fracture(s)?	YES – NO – Don't Know
Do you wear any protective braces or equipment for any prior injury	YES – NO – Don't Know

Has the student had or currently have any of the following general or exercise-related conditions since their last physical?

Difficulty breathing during physical activity? After running one mile?	YES – NO – Don't Know
Coughing, wheezing or shortness of breath in weather changes?	YES – NO – Don't Know
Been told he/she has exercise-induced asthma Controlled with medication? [list below]	YES – NO – Don't Know
Experience dizziness, passing out or fainting?	YES – NO – Don't Know
Viral infections (e.g. mono, hepatitis)?	YES – NO – Don't Know
Become tired more quickly than friends?	YES – NO – Don't Know
Any of the following skin conditions: Acne, contact dermatitis, ringworm, warts, herpes?	YES – NO – Don't Know
Sensitivity to the sun?	YES – NO – Don't Know
Weight gain/loss (greater than or less than 10 pounds)? Wants to weigh more or less than he/she is now?	YES – NO – Don't Know
Ever had/has feelings of depression?	YES – NO – Don't Know
Heat-related problems (dehydration, dizziness, fatigue, headache)? Heat exhaustion? (cool, clammy, damp skin)	YES – NO – Don't Know
Heat stroke? (hot, red, dry skin)	YES – NO – Don't Know

Please explain all "YES" answers here and be sure to include dates where possible:

I certify the information provided herein is accurate as of the date stated on this form:

x _____
Parent/Guardian Signature

_____ 2009
Date

Student Health Information and Release

Student Name	Parent/Guardian Name
Family Doctor Name	Family Doctor Address
Family Doctor Phone	
Hospital Preference [circle one] <div style="text-align: center;">UMDNJ – Newark Beth Israel – Other: _____</div>	
Medical Insurance Company	Insurance Policy Number
Allergies	Food
Bee stings [circle one] YES – NO	Medication
List your child's health problems, if any	List your child's medications, if any
My child may be checked by the school nurse for [please circle]	
Scoliosis YES – NO	Vision YES – NO
Hearing YES – NO	
Health information may be shared with teachers/staff [circle one] YES – NO	
The school nurse may contact your health care provider [circle one] YES – NO	
Medical information may be released to the school nurse [circle one] YES – NO	

In the event a parent/guardian cannot be reached, I hereby give permission to TEAM Charter Schools to obtain emergency medical treatment for the above-named child, including x-rays, and to release information pertaining to my child's health record, diagnosis, condition or health history, including any subsequent diagnosis which could supplement this form. This information may be released by a properly authorized representative of the school responsible for my child during periods of time when the school nurse is unavailable or when the student is away from the school building (i.e. during field trips).

X _____
Parent/Guardian Signature

_____ 2009
Date

**New Jersey Department of Health and Senior Services
Vaccine Preventable Disease Program
PO Box 369
Trenton, NJ 08625-0369**

**ANNOUNCING
THE NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)**

To New Jersey Parents and Guardians:

In order to attend any licensed day care, preschool, public, parochial or private school in New Jersey, your child must meet state mandated immunization requirements. A record of these immunizations, supplied by your healthcare provider, is maintained by the school on a state approved form (A45). This record is essential for admission to any new school to which your child transfers, for entrance into high school and for college entrance. The New Jersey Immunization Information System (NJIIS) has been developed to provide a confidential population-based electronic database that collects and stores vaccination data for New Jersey residents. This registry is already in use at more than 400 sites throughout New Jersey, with more than 600,000 patient records currently in the system. The immunization Information System is the first step in creating electronic health records for New Jersey school students.

New Jersey public schools are assisting in this project by inputting data from the student's Immunization Record. Participation in this program is free and will provide you with a permanent record of your child's immunizations, as well as reminders of the need for any additional doses. It will exist for your child long after graduation when immunization records may be needed for foreign travel or other situations. It will be available to you for summer camp requirements and should you change healthcare providers.

Your child's immunization record is confidential. It is available only to you, the Health Department and its related service agencies (your child's school) and the health provider(s) you choose. If you change providers, only the new provider will be able to send you reminders.

To enroll in the system, simply sign the consent form on the back of this letter and return it to your child's school nurse within seven days.

If you have any questions, you may call your child's school nurse.

We hope that you will take advantage of this opportunity to promote the well being of your child.

**PLEASE COMPLETE THE REVERSE SIDE OF THIS SHEET AND
RETURN IT TO YOUR CHILD'S SCHOOL NURSE!**

- OVER -

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)

CONSENT TO PARTICIPATE

- PLEASE PRINT CLEARLY -

CHILD INFORMATION	PARENT/GUARDIAN INFORMATION
Name	Name
Date of Birth	Relationship
Address	Address

I have read the information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to keep a central record of my child's immunization history and to remind me when immunizations are due. I understand that I can obtain a copy of my child's record from my medical provider, my local health department, or my child's school nurse.

There is no cost to participate in this program.

YES, I would like to participate in this program.

NO, I do not wish to participate in this program.

Parent / Guardian Signature	Date
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**New Jersey Department of Health and Senior Services
Vaccine Preventable Diseases Program
PO Box 369
Trenton, NJ 08625-0369**

PLEASE RETURN THIS FORM TO YOUR CHILD'S SCHOOL NURSE WITHIN 7 DAYS

Walking Field Trip Permission Slip & Ride Waiver

Each year teachers and students take walks in the neighborhood as part of their instructional program. These walks include trips to nearby parks and other locations within a mile of our schools. In addition, students sometime receive rides from staff members or volunteers while on school trips or small group outings. To facilitate these trips, we ask you to sign a blanket permission form.

Please be advised that the school nurse will not be accompanying the staff and students on school trips. Parents or guardians are responsible to ensure that their child has their respective medications and are properly educated on the use of any prescribed medications or treatments that may be needed during this trip. Also, teachers are not responsible for administering medications.

Sincerely,



Ryan Hill
Executive Director
TEAM Charter Schools

Please check all that apply:

- My child may participate in neighborhood walks or receive rides from school staff members or volunteers.
- My child may NOT participate in neighborhood walks or receive rides from school staff members or volunteers.
- My child does not take any medication.
- I understand that my child will/may need medications during this trip & has been properly educated on their use.

x _____
Parent/Guardian Signature

_____ 2009
Date