UNION TOWNSHIP PUBLIC SCHOOLS
UNION, NEW JERSEY 07083

Please complete this form, together with the student, and return it with the student for the next school session day. This will greatly assist school health personnel in updating health records and in physical evaluation of the student.

Name of person completing form_________________________Date_______________

Student's
Name_____________________________
Address___________________________
Phone_____________________________
Date of Birth_______________________
Date of last
Tetanus Booster_____________________

Notify in
Emergency__________________
Address______________________
Phone________________________
Family M.D.__________________
Phone_________________________

	YES	NO
Does student want to talk to a school nurse about health problem or injury?	____	____
Has anyone in student's close family ever had		
Diabetes (high sugar in blood) ?	____	____
Allergies (hay fever or asthma)?	____	____
Migraine headaches?	____	____
Heart trouble?	____	____
High blood pressure?	____	____
Sudden death?	____	____
Has student had or does student have		
Tendency to lose consciousness (faint) ?	____	____
Convulsions or epilepsy?	____	____
Heart trouble?	____	____
High blood pressure?	____	____
Persistent cough?	____	____
Chest pain with exercise?	____	____
Dizziness or faintness with exercise?	____	____
Has student had or does student have		
Very bad (impaired) vision in one eye?	____	____
Temporary loss of vision?	____	____
To wear glasses or contact lenses?	____	____

	YES	NO
Has student had or does student have		
Hearing loss?	____	____
Perforated ear drum?	____	____
Sinus infection?	____	____
Broken nose?	____	____
Orthodontia (teeth straightened)?	____	____
Has student had or does student have		
Kidney problems?	____	____
(Boys) Loss of function or absence of testicles?	____	____
(Girls) Menstrual problems?	____	____
Age of onset of menstruation_______________		
Has student had or does student have		
Asthma (wheezing)?	____	____
Hay fever?	____	____
Hives or rash?	____	____
Bee sting reactions (allergy)?	____	____
Reaction to medicine (allergy)?	____	____
Has student or does student		
Smoke?		
Take any medicine regularly?	____	____
If yes, name_________________________		
Take medicine for emergency use?	____	____
If yes, name_________________________		
Has student or does student have any injury?	____	____
Has student had or does student have		
Tendency to bleed or bruise easily?	____	____
Anemia ("tired" blood)?	____	____
Weight problem (under or overweight)?	____	____
Has student had or does student have a skin condition?	____	____
If yes, name_______________________________		
Does student wish to discuss an emotional problem with the nurse?	____	____
Has student ever been told to give up sports because of health problems?	____	____

Additional information concerning "YES" checked above:_________________________

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