

**MONMOUTH BEACH SCHOOL
MONMOUTH BEACH, NEW JERSEY**

HEALTH HISTORY UPDATE

Student's Last Name	First	Middle	Sex	DOB
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Address	Phone
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Parent's Names _____

1. Child was: _____ full term _____ premature _____ no. of weeks early

2. Complications at birth: Yes No

Breathing difficulty	_____	_____
Jaundice	_____	_____
Blue color	_____	_____
Other	_____	_____

3. Is there any family history of: (Please check)

Allergies _____	Diabetes _____	Heart Disease _____
Asthma _____	Epilepsy _____	Kidney Condition _____
Cancer _____	Hearing Problem _____	Visual Problem _____

4. Student's Health History: (Please check if applicable and give dates)

Allergies _____		
Bee Sting Allergy _____		
Food Allergy _____		
Latex Allergy _____		
Peanut Allergy _____		
Asthma _____	Emotional Problems _____	Strep Throat _____
Bed Wetting _____	Frequent Headaches _____	Speech Problem _____
Bronchitis _____	Epilepsy _____	Scarlet Fever _____
Chronic Ear Infections _____	Hearing Problem _____	Tuberculosis _____
Concussion _____	High Fevers _____	Visual Problem _____
Convulsions _____	Mononucleosis _____	Wears Glasses _____
Frequent Sore Throats _____	Tantrums _____	distance _____ close _____ all times _____
Hernia _____	Nightmares _____	Operations _____
Pneumonia _____	Weight problem _____	Urinary Infec. _____

5. Does the student take medication on a regular basis? Yes _____ No _____
Please list medication and condition _____

6. Immunization Record: Yes _____ No _____

7. Is there anything else, which you feel would be helpful for school personnel to know about your child; e.g., physical limitations or medical problems? Are there any special circumstances, which might affect your child's school performance? _____

8. I give my permission for the school nurse to share information concerning my child's health to those faculty/staff members who may need to know. I recognize that sharing this information is important to my child's well being while attending school.

Date	Signature of Parent or Guardian	(Rev. 2/09)
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