CHERRY HILL PUBLIC SCHOOLS
SCHOOL HEALTH SERVICE
HEALTH HISTORY QUESTIONNAIRE (PreK-1)

Child's Name_____ Birth Date/Age:_____ Gender: _____

Child's Nickname: _____Grade_____ School_____

Name of Parents/Guardians_____

Address_____ Phone_____

List all members of household:

Name	Relationship	Age of Child/School
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is another language spoken at home? _____ If yes, what language? _____

PERINATAL / BIRTH HISTORY

Did mother have any problems/illnesses during the pregnancy or birth? Yes ____ No_____ If yes, explain briefly
_____

Was the child born full term _____ early_____ late_____?

Did your child have any illnesses or problems as a newborn? Yes____ No____ If yes, explain briefly_____
_____

CURRENT HEALTH

Is your child currently receiving medical treatment? If yes, explain_____
_____

Is your child currently taking medication? If yes, explain_____
_____

HEALTH CONDITIONS HISTORY

Does your child have any of the following concerns?

	Yes	**No**	**Year**	**If yes, please explain**
Allergies				
Asthma/Respiratory				
Bladder/Bowel				
Cardiac/Heart				
Chicken Pox/Communicable Diseases				
Dental/Orthodontic				
Dermatologic/skin				
Diabetes				
Digestive/GI/Stomach aches				
Endocrine				
Frequent Illness/Strep				
Headaches				
Hearing Problem				
Hospitalizations				
Neurological				
Orthopedic Injuries/fractures				
Seizures				
Urinary/Bladder/Renal				
Vision Problem/Glasses				
Other				

Are there any additional health concerns that you would like the nurse and/or school staff to be aware of?_____

I give permission for the school nurse to share this information with the appropriate school personnel.

_____ _____

Parent/Guardian Signature Date

Revised April, 2020