Ventnor Educational Community Complex
400 North Lafayette Avenue
Ventnor, NJ 08406
(609) 487-7900 x 5310
www.veccnj.org

MEDICAL HISTORY QUESTIONNAIRE

This form must be completed and signed by the parent or legal guardian.

Student's Name: _____ Birthdate: _____ Gender: M / F Grade: _____

Please Circle A Response:

Yes No 1. What did your child weigh at birth _____ lbs.? _____ ounces. Were there any complications during pregnancy, birth or delivery?
If yes, explain: _____

Yes No 2. Has the student ever been advised by a physician not to participate in any sport or physical activity? If yes, explain. *Include any written documentation from your child's health care provider:
_____

Yes No 3. Is the student presently under a physician's care?
If yes, explain: _____

Yes No 4. Has the student ever experienced a loss of consciousness after an injury?
if yes, explain: _____

Yes No 5. Has the student ever had a dislocation or fractured bone?
Describe: _____ Date: _____

Yes No 6. Does the student take medication on a regular basis?
If yes, the name of medication: _____
For what condition? _____

Yes No 7. Does the student have food, medication or other allergies which require medical intervention if they ingest or come in contact with it?
If yes, to what? _____
Describe the signs and symptoms (i.e.: localized swelling; anaphylactic reaction etc.) and how it is treated: _____
PLEASE NOTE; ACCORDING TO STATE/FEDERAL REGULATIONS DOCUMENTATION FROM YOUR CHILD'S HEALTH CARE PROVIDER IS NECESSARY FOR ANY FOOD ALLERGY CONDITION OR WHEN MEDICAL INTERVENTION IS NECESSARY

Yes No 8. Does the student have asthma? If yes, describe causes/symptoms and list any medications prescribed:
_____

Yes No 9. Does the student have a reaction to bee stings which requires emergency medication and/or immediate physician care? If yes, please name the medication: _____

Yes No 10. Has the student ever experienced frequent chest pains or palpitations?
If yes, explain: _____

Yes No 11. Has the student recently suffered fatigue, undue tiredness or fainting with exercise?
If yes, explain: _____

Yes No 12. Has any family member suffered sudden death?
If yes, explain: _____

Yes No 13. Has the student had any medical problems (ex. strep throat, ear infections…), hospitalizations or surgeries in the past year?
If yes, explain: _____

Yes No 14. Does your child have any other medical problems that the school should be aware of? If yes, explain: _____

The following questions are required by the New Jersey Department of Education

Yes No 15. Does your child have Health Insurance?

If Yes, Name of Insurance Company: _____

If No, NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online.

Yes No 16. You may release my name and address to the NJ Family Care Program to contact me about health insurance.

Date of Last Dental Exam: _____ Braces: yes _____ no _____

Date of Last Eye Exam: _____ Glasses: yes ____ no____ Contacts: yes ____ no _____

Name of Student's Health Care Provider: _____ Telephone: _____

Name of Student's Dentist: _____ Telephone: _____

PLEASE NOTE:

Epinephrine - Please be advised that should your child experience a life-threatening allergic reaction, Emergency Medical Services will be activated and epinephrine may be administered by the School Nurse as per District Policy and District Standing Orders. Those students with known anaphylaxis will be cared for in accordance with their physician's orders.

Health Screenings - Your child will have a limited health screening, which will consist of measuring the height, weight, blood pressure, and heart-rate, as well as basic vision and hearing testing. This will be performed by the school nurse during the current school year as per state and district requirements. A referral will be sent home if your child requires follow-up by their health care provider.

Scoliosis - In addition, students in grades 5 and 6 will be assessed for scoliosis during their health screening. Scoliosis screening requires the removal of the student's blouse or shirt. Boys and girls are screened separately and individually in a private screening area.

If you do not wish for your child to be screened in school, please submit this request in writing to the school nurse within 7 days of receipt of this notice. **This request will need to be renewed in writing on a yearly basis.** It will then become the parent(s)/guardian's responsibility to have your child examined by his or her health care provider.

The information on this form may be shared with School Personnel having contact with my child. In the event of an emergency, this information can also be give to ambulance/hospital personnel.

In the event that the parents/guardians or health care provider cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child

Parent/Guardian Signature: _____ **Date:** _____

Printed Name: _____
Written consent required pursuant to 20 U.S.C. § 1232g (b) (1) and 34 C.F.R. 99.30 (b).