MENDHAM BOROUGH SCHOOL DISTRICT
HEALTH ASSESSMENT RECORD

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Universal Child Health Record).

State law requires complete primary immunization and a medical examination by a physician licensed to practice medicine or osteopathy, a certified registered nurse practitioner, /clinical nurse specialist or licensed physician's assistant prior to school entrance in a New Jersey school district.

Kindergarten entrance physicals must be completed prior to entry. Students moving into the district are allowed up to 60 days from date of registration to provide the school nurse with the completed Health Assessment Record. Transfer students must provide a complete immunization record within 30 days of registration.

This examination must be performed no more than 365 days prior to entry.

Please Print

Name of Student (Last, First, Middle)	Birth Date ____ ____/____ ____/____ ____ ____ ____	Sex
Address (Street)	Home Phone # (including area code)	Cell Phone #
Town and Zip Code	Student's Physician or Primary Health Care Provider	
Parent/Guardian - Mother (Last, First, Middle)	Parent/Guardian - Father (Last, First, Middle)	

Part I – To be completed by parent – *Important*: Complete Part I before your child is examined.
Take this form with you to the health care provider's office.

Please check yes or no to the following questions (explain all **"yes"** answers in the space provided below.)

	YES	NO	
1	☐	☐	Do you have any concerns about your child's general health (eating and sleeping habits, weight, teeth, etc)?
2	☐	☐	Does your child have any other specific illness, physical deformity or health condition (asthma, diabetes, heart murmur, seizures, etc.)?
3	☐	☐	Does your child have any restrictions on physical activity?
4	☐	☐	Does your child have any allergies (food, insects, medication, etc.)?
5	☐	☐	Does your child take any medication (daily or occasionally)?
6	☐	☐	Does your child have any difficulty with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?
7	☐	☐	Has your child had any hospitalization, operation, or major illness (specify)?
8	☐	☐	Has your child had any significant injury or accident (specify)?
9	☐	☐	Are you claiming exemption from immunization guidelines?
10	☐	☐	Have there been any recent changes in the family (relocation, death, divorce, etc.)?
11	☐	☐	Would you like to discuss anything about your child's health with the school nurse?

This child is number _____ of _____ children.

(Please explain any **"yes"** answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time)

_____

_____

_____

I give limited permission for release of essential information on this form for confidential use in the school for meeting my child's health and educational needs.

_____ _____

Signature of parent/Guardian Date

This school nurse may be reached at the following numbers:

Mountain View School 973-543-7075 extension 246
or
Hilltop School 973-543-4251 extension 142

(To be maintained in student's Cumulative School Health Record)