

TRENTON PUBLIC SCHOOLS  
Trenton, New Jersey  
Medical Department

SH 2

PUPIL HEALTH HISTORY

Pupil's Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Identification Number \_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Parent/Guardian's Name \_\_\_\_\_ Telephone Work \_\_\_\_\_  
Usual Care Provider: (check) Private Physician \_\_\_ HMO \_\_\_ H.J. Austin Health Center \_\_\_ Clinic \_\_\_  
Doctor's Name \_\_\_\_\_ Telephone number \_\_\_\_\_

Health History and Development:

- Length of pregnancy \_\_\_\_\_ months Delivery (circle one) Normal, Caesarian, Premature  
Birth weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz.  
Problems at birth or delay sending newborn home. If yes, explain \_\_\_\_\_
- Birth sequence of above child 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_ other \_\_\_\_\_
- What age did your child walk \_\_\_\_\_ talk \_\_\_\_\_ toilet-train \_\_\_\_\_
- Does your child have any of the following problems?  
Vision \_\_\_\_\_ Hearing \_\_\_\_\_ Speech \_\_\_\_\_
- Does your child take medications? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_
- Is your child allergic to food, plants, dust, dogs, cats, bees, other? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain \_\_\_\_\_
- Has your child had a serious injury? Yes \_\_\_\_\_ Year \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain \_\_\_\_\_
- Has your child ever had an operation or medical procedure requiring outpatient services or hospitalization? Yes \_\_\_\_\_ Year \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_
- Has your child been tested for lead poisoning? Yes \_\_\_\_\_ No \_\_\_\_\_ Results \_\_\_\_\_

Disease History (Age)

Measles _____	German Measles _____	Mumps _____
Scarlet Fever _____	Whooping Cough _____	Asthma _____
Pneumonia _____	Ear Infections _____	Tuberculosis _____
Convulsions _____	Tubes in ears _____	Chicken Pox _____
Polio _____		Epilepsy _____
Heart Disease _____	Sickle Cell _____	
Anemia _____	Fractures _____	Frequent Sore throats _____
Frequent headaches _____	Liver Disease _____	Diabetes _____
Frequent nosebleeds _____	Lyme Disease _____	Tonsillitis _____

Any restrictions or limitations to physical activity? \_\_\_\_\_  
Is there anything about your child's health not mentioned above that we should know?  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

CONFIDENTIAL INFORMATION