TOMS RIVER REGIONAL SCHOOLS

Health Office-New Entrant Questionnaire

Student Name:_____ DOB:_____ Date_____

Birthplace:_____ Age:_____ Sex:_____ Grade:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS AND EXPLAIN ANY "YES" ANSWERS IN THE SPACES PROVIDED

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MEDICATIONS: Taken Daily? ▫ **YES** ▫ **NO** **If YES**, List names and doses:_____

_____

Medication required during school hours? ▫ **YES** ▫ **NO** **If YES**, Please see Nurse for instructions

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ALLERGIES: Life threatening? ▫ **YES** ▫ **NO** Medication Required? ▫ **YES** ▫ **NO**

If YES, Please see Nurse for Instructions

Medication type: ▫ **EpiPen** ▫ **Benadryl** ▫**Other**_____

ALLERGY TYPE: ▫ **Insect Sting/Bite** ▫ **Food** ▫ **Medication** ▫ **Seasonal** ▫ **Other**

Specify Allergy Name/Type of reaction: _____/_____

_____/_____

_____/_____

_____/_____

ASTHMA: ▫ **YES** ▫ **NO** ▫ **SEASONAL** ▫ **WEATHER RELATED** ▫ **ILLNESS RELATED**

Known triggers: _____

Frequency of attacks (estimated):

▫ **REGULARLY (1-2x a week)** ▫ **Occasionally (1-2x a month)** ▫ **RARELY (1-2x a year)**

Current Daily Asthma Medications:_____

**See Nurse if Medication will be required to be kept in school*

HEART DISEASE: ▫ **YES** ▫ **NO** **Heart Murmur:** ▫ **YES** ▫ **NO** **Diagnosed by a Doctor?** ▫ **YES** ▫ **NO**

Specify type of condition: _____

PLEASE NOTE: *Child will not be permitted to participate in Gym, Health or Recess without a Cardiac Clearance Note from Physician. See Nurse for further instructions.*

DIABETES: ▫ **YES** ▫ **NO** **If YES,** *We will discuss and formulate a care plan for the school year.*

SEIZURE DISORDER: ▫ **YES** ▫ **NO** **FEBRILE EPISODES** ▫ **OTHER** **Diagnosed by a Doctor?** ▫ **YES** ▫ **NO**

Specify _____

If YES, *We will discuss and formulate a care plan for the school year.*

Medications / Limitations: _____

Date of Last Seizure: _____ Type: _____

Other Neurological Disorder: ▫ **YES** ▫ **NO** **Diagnosed by a Doctor?** ▫ **YES** ▫ **NO**

Specify type of condition:_____

KIDNEY DISEASE: ▫ **YES** ▫ **NO** Specify type of condition:_____

LYME Disease: ▫ **YES** ▫ **NO** **If YES, Diagnosis Date**_____

Medications / Limitations_____/_____

HEALTH OFFICE NEW ENTRANT QUESTIONNAIRE: Continued

EYES: ▫ **GLASSES** ▫ **CONTACTS** ▫ **BOTH** ▫ **ALL THE TIME** ▫ **AS NEEDED**

Disorder (Specify): _____ Last eye exam_____

NOSE: ▫ **NOSE BLEEDS** ▫ **NASAL DISCHARGE** ▫ **SINUS INFECTIONS** ▫ **FREQUENT** ▫ **OCCASIONAL**

EARS: **HEARING DIFFICULTIES** ▫ **YES** ▫ **NO** ***If YES:*** **HEARING AID** ▫ **YES** ▫ **NO**

AUDITORY PROCESSING DISORDER ▫ **YES** ▫ **NO**

FREQUENT EAR INFECTIONS ▫ **YES** ▫ **NO** **If YES, how many and what age(s)?**_____

MOUTH / THROAT: ▫ **DENTAL CAVITIES** ▫ **FREQUENT STREP INFECTIONS** ▫ **ENLARGED TONSILS**

Other concerns_____

History of any of the following (check all that apply, give dates and explain below):

▫ **HEAD INJURIES** ▫ **BROKEN BONES** ▫ **HOSPITALIZATIONS** ▫ **SURGERIES**

_____/_____

_____/_____

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Please check any of the following *diagnosed or under evaluation by a physician*, and provide supporting medical documentation.

▫ **AUTISM / ASD / Asperger's Syndrome** ▫ **ADD / ADHD** ▫ **Anxiety Disorder / OCD**
▫ **Disruptive Behavioral Disorder** ▫ **Dissociative Disorder**
▫ **BEHAVIORAL / EMOTIONAL DISORDER** ▫ **Pervasive Developmental Disorder**
▫ **MOOD DISORDER**

LEARNING DISORDER: ▫ ***Dyslexia*** ▫ ***Dyscalculia*** ▫ ***Dysgraphia*** ▫ ***Oral / Written Language Disorder*** ▫

Non-Verbal Learning Disabilities ▫ ***Dyspraxia*** ▫ ***Executive Function*** ▫ ***Apraxia*** ▫ ***Speech Disorder***

Other Learning Disorder:_____

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Please list any other disabilities, limitations or health concerns not already addressed or check ▫ N/A:

_____

_____

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PREVIOUS SCHOOL ATTENDED- Name_____

Address_____

Phone____(_____)_____-_____ **Last Date Attended:**_____

Parent Signature:_____ **Date:**_____

Does this child have any health insurance, including NJ Family Care / Medicaid, Medicare, private or other?

▫ **YES Name of Insurance Company**_____ ▫ **NO, but you may release my name and address to the NJ FamilyCare Program to contact me about health insurance.**

Signature:_____**Printed Name:**_____**Date:**_____

Written consent required pursuant to 20 U.S.C. & 1232g (b)(1) and 34 C.F.R. 99.30 (b)

***NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information, call 1-800-701-0710 or visit www.njfamilycare.org to apply online.**

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