Abundant Life Academy **New Student Health Survey**

Student' Name: _____ Birthdate: _____Gender: _____

Pediatrician's Name/Phone: _____ #: _____

Please check if your child has had the following:

Condition	Yes	No	Year	Condition	Yes	No	Year
High Blood Pressure				Heart Condition			
Asthma				TB or contact with TB			
Severe Allergies				Severe or Chronic Stomach Problems			
Frequent or Painful Urination				Wets or Soils Pants			
Concussion				Frequent or Severe Headaches			
Dizzy or Fainting Spells				Severe Head Injury			
Epilepsy or Seizures				Excessive Worry or Anxiety			
Depression				Hearing Loss			
Speech Problems				Eye Problems			
Frequent Ear Infections				Frequent Colds			
Wears Glasses or Contacts				Diabetes			
Scoliosis				Tumor			
Cancer				Serious Skin Disease			

Please explain any "Yes" answers: _____

_____

1. Has your child ever had any serious illnesses or injuries other than those already noted? What? When?

   Please explain: _____
2. List any medications or foods your child is allergic to: _____
3. Has your child been diagnosed with Attention Deficit Hyperactivity Disorder (or similar condition)? Explain:

   _____ List medications: _____
4. Has your child had any operations? What? When? Explain: _____

   _____
5. Has your child had any orthopedic (bone/joint) problems? What? When? Explain: _____

   _____
6. Does your child have severe bee/insect sting sensitivity? Local _____ General _____ How do you treat?

   _____
7. Does your child have any other health or behavior problems the nurse should be aware of? Explain:

   _____
8. Is your child under regular medical supervision for any of the above conditions? If yes, name and phone number of doctor: _____

Please contact the school nurse if you have any questions. 973-667-9700

_____ _____

Parent/Guardian Signature **Date**