RIVER VALE SCHOOL DISTRICT

HEALTH HISTORY

Child's Name: _____
Last *First* *Middle*

1. Is your child currently under the care of a medical doctor? ☐ Yes ☐ No
   If yes, please explain. _____
2. Does your child take any medication on a daily basis? ☐ Yes ☐ No
   If yes, please explain. _____
3. Does your child have any condition, which prevent participation in a physical education class? ☐ Yes ☐ No
   If yes, please explain. _____
4. Has your child had any surgeries? ☐ Yes ☐ No
   If yes, please explain. _____
5. Has your child had any hospitalizations? ☐ Yes ☐ No
   If yes, please explain. _____
6. Does your child have or ever had:

Allergies	☐ Yes	☐ No	Muscular Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Nosebleeds	☐ Yes	☐ No
Congenital Defects	☐ Yes	☐ No	Orthopedic Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Hearing Problems	☐ Yes	☐ No	Serious Injury	☐ Yes	☐ No
• Hearing Aid	☐ Yes	☐ No	Serious Illness	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No	Tendency to Bleed	☐ Yes	☐ No
Migraines	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Mononucleosis	☐ Yes	☐ No	• Contact Lenses	☐ Yes	☐ No
			• Eye Glasses	☐ Yes	☐ No

Does your child have any medical concerns? Please explain.

Please notify the School Nurse of any medical problems, serious illness, communicable disease, or if your child receives any immunizations. Also, please note that New Jersey law requires both doctor and parent permission for taking medication in school. Without both signed permission statements, the nurse CANNOT give the medication, even if you send it to the school.

I certify that all of the information contained in this Health History form is true under the penalties as prescribed by the laws of the State of New Jersey and the United States Government.

_____ _____
Signature of Parent/Guardian completing this registration form Date