MONTCLAIR PUBLIC SCHOOLS

Elementary School Health Survey

Student's Name ____

Date of Birth __________________________

Please check if your child has the following:

- ☐ Allergies - life-threatening
- ☐ Allergies - non life-threatening
- ☐ Anxiety and/or depression
- ☐ Asthma
- ☐ Bladder or bowel issues (wets/soils)
- ☐ Cancer
- ☐ Chronic headaches
- ☐ Concussion/head injury
- ☐ Diabetes
- ☐ Diagnosed with add
- ☐ Eyeglasses or hearing aids
- ☐ Food intolerances
- ☐ Frequent colds
- ☐ Frequent ear infections
- ☐ Frequent nosebleeds
- ☐ Frequent stomachaches
- ☐ High blood pressure
- ☐ History of surgery
- ☐ Hypertension
- ☐ IEP
- ☐ Orthopedic problems
- ☐ Routine medication at school or at home
- ☐ Scoliosis
- ☐ Seizure disorder
- ☐ Speech problems

Please explain:

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Normal pregnancy and delivery? _____ Yes _____ No

Additional information you would like to share with the school nurse:

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Parent/Guardian Signature ____

Date _________________________________