PLAY AND LEARN SCHOOL
JERSEY CITY PUBLIC SCHOOLS
EARLY CHILDHOOD DEPARTMENT
346 CLAREMONT AVENUE
JERSEY CITY, NEW JERSEY 07035
(201) 915-6078

EARLY CHILDHOOD HEALTH HISTORY QUESTIONNAIRE

Student's Name _____ Date of Birth _____

Parent/Guardian _____

Address _____

Daytime Phone # _____ Cell/Emergency # _____

Child's Doctor _____ Doctor's Phone # _____

Doctor's Address _____

Prenatal

Were you sick during your pregnancy? Yes _____ No _____
If Yes, please explain _____
Full Term _____ Premature _____ Complications _____
What type of delivery did you have? Normal _____ C-Section _____

Neonatal

How much did your baby weigh at birth? _____
Was your baby sick in the first few days of life? Yes _____ No _____
If Yes, please explain _____

Developmental Milestones (age at which the child)

Sat Up _____ Crawled _____ Walked _____ Talked _____ Toilet Trained _____

Health Problems

Has your child ever had any of the following?

	No	Yes	Age		No	Yes	Age
Heart Disease	___	___	___	Seizure/Convulsion	___	___	___
Fainting	___	___	___	Diabetes	___	___	___
Kidney Disease	___	___	___	Ear Infections	___	___	___
Sickle Cell	___	___	___	Lead Poisoning	___	___	___
Hearing Problem	___	___	___	Learning Problem	___	___	___
Vision Problem	___	___	___	Broken Bones	___	___	___
Surgery	___	___	___	Asthma	___	___	___

CONTINUED ON NEXT PAGE>>>>>>>>>>>

Explain and "Yes" answers and list any other health problems.

_____

_____

_____

Activity Restrictions specified by MD (note required) _____

Hospitalizations

Has your child ever been hospitalized for any reason? Yes _____ No _____
Reason for hospitalization _____ How many days? _____ Year _____
Reason for hospitalization _____ How many days? _____ Year _____

Asthma

Has your child ever had asthma? Yes _____ No _____
How often does your child have asthma attacks? _____
What triggers your child's asthma? _____
Has your child used asthma medicine in the past 2 years? Yes _____ No _____
If Yes, please indicate medicine used _____

Allergies

To Food? Yes _____ No _____ To Medicine? Yes _____ No _____
If Yes, please list things child is allergic to and indicate symptoms:

_____

_____

Anaphylaxis? Yes _____ No _____ EPI Pen Yes _____ No _____

Medications

Does your child take any prescription medication at home? Yes _____ No _____
If Yes, please list medicine(s) _____
Will your child be taking prescription medicine at school? Yes _____ No _____
If Yes, what medicine(s)? _____

Parent/Guardian Signature _____ Date _____

I GIVE PERMISSION TO SHARE THIS INFORMATION WITH STAFF MEMBERS INVOLVED IN MY CHILD'S CARE AND EDUCATION.

Parent/Guardian Signature _____ Date _____

Reviewed by _____ Date _____

Early Childhood Nurse's Signature