Galloway Township Public Schools
101 South Reeds Road
Galloway, NJ 08205
(609) 748-1250
http://www.gtps.k12.nj.us

MEDICAL HISTORY QUESTIONNAIRE

This form must be completed and signed by the parent or legal guardian of each student. This form is necessary for participation in sports.

Student's Name: _____ Birthdate: _____ Grade: _____

Please Circle A Response:

Yes No 1. Has the student been advised by a physician not to participate in any sport?
If yes, explain: _____

Yes No 2. Is the student presently under a physician's care?
If yes, explain: _____

Yes No 3. Has the student ever experienced a loss of consciousness after an injury?
If yes, explain: _____

Yes No 4. Has the student ever had a dislocation or fractured bone?
What? _____When? _____

Yes No 5. Has the student ever been hospitalized or undergone surgery?
Why? _____ When? _____

Yes No 6. Does the student take medication on a regular basis?
If yes, the name of medication: _____
For what condition? _____

Yes No 7. Does the student have allergies?
If yes, to what? _____
Describe the signs and symptoms and how they are treated: _____
_____

Yes No 8. Does the student have asthma?
If yes, explain: _____

Yes No 9. Does the student have a reaction to bee stings?
If yes, describe the signs, symptoms and treatment: _____
_____

Yes No 10. Has the student ever experienced frequent chest pains or palpitations?
If yes, explain: _____

OVER>>>>

Yes No 11. Has the student recently suffered fatigue or undue tiredness?
If yes, explain: _____

Yes No 12. Does the student have a history of fainting with exercise?
If yes, explain: _____

Yes No 13. Has any family member suffered sudden death?
If yes, explain: _____

Yes No 14. Has the student had any ear infections in the past year?
If yes, explain: _____

Yes No 15. Does the student wear glasses and/or an orthodontic appliance?
If yes, explain: _____

Yes No 16. Do you currently have health insurance?

Yes No 17. Do you have vision insurance?

Yes No 18. Do you have dental insurance?

Yes No 19. Would you be interested in receiving information about New Jersey Family Care, a state sponsored insurance program for working people who are uninsured?

Yes No 20. Does your child have any other medical problems that the school should be aware of? If yes, explain: _____

PLEASE NOTE:

Epinephrine - Please be advised that should your child experience a life-threatening allergic reaction, Emergency Medical Services (EMS) will be activated and epinephrine may be administered by the School Nurse as per District Policy and District Standing Orders. Those students with known anaphylaxis will be cared for in accordance with their physician's orders.

Health Screenings - Your child will have a limited health screening, which will consist of measuring the height, weight, blood pressure, and heart-rate, as well as basic vision and hearing testing. This will be performed by the school nurse during the current school year as per state and district requirements. A referral will be sent home if your child requires follow-up by their health care provider.

Scoliosis - In addition, students in grades 5 and 6 will be assessed for scoliosis during their health screening. Scoliosis screening requires the removal of the student's blouse or shirt. Boys and girls are screened separately and individually in a private screening area.

If you do not wish for your child to be screened in school, please submit this request in writing to the school nurse within 7 days of receipt of this notice. **This request will need to be renewed in writing on a yearly basis**. It will then become the parent(s)/guardian's responsibility, as desired, to have your child examined by his or her health care provider.

The information on this form may be shared with School Personnel having contact with my child. In the event of an emergency, this information can also be give to ambulance/hospital personnel.

_____ _____

Parent's/Guardian's Signature Date