

Alexandria Township Schools

Lester D. Wilson School
525 County Rd. 513
Pittstown, NJ 08867

Telephone (908)996-6812
Fax (908)996-3163

Date _____

Child's Name _____ Grade _____ Teacher _____

Mailing Address _____

Sex: Male ___ Female ___ Transfer from: _____

Parent () Guardian () Relationship _____

Father _____ Age ___ Occupation _____ Level of Education _____

Mother _____ Age ___ Occupation _____ Level of Education _____

Other Children in the district: Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Present Doctor _____

Please answer all questions below:

1. Does your child have any of the following? (Please check)

Asthma ()

Orthopedic (Bone problems) ()

Diabetes ()

Heart Disease ()

Epilepsy/seizures ()

Heart Murmur ()

Kidney Problems ()

Headaches ()

Bleeding Problems ()

Hyperactivity or Attention Problems ()

Other () _____

Nervous habits ()

Bed Wetting or wetting in the day ()

Please explain any problems checked _____

2. Does your child have severe allergies? (Medicine, Food, Insect bites, etc.)

Yes () No () If yes, list them and describe what happens to the child:

Does your child take medicine for allergy reaction? Yes () No ()

If yes, please list the medicine and if it will be sent to the school for us to keep for the child to use if necessary. (Written authorization is needed from both the doctor and the parent for any medication, please contact the school nurse)

3. Does your child take medicine for a chronic illness or for a behavioral condition?

Yes () No () If yes, list medicine and illness _____

Will medicine be taken in school? Yes () No () If yes, written authorization will be needed from the parent and doctor, listing diagnosis, medication, dose, time, and side effects.

(Over)

Medical History

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4. Has your child ever been hospitalized? Yes () No ()

If yes, why? _____

5. Has your child received any immunizations in the last year? Yes () No ()

If yes, list name, date, and please provide documentation from the Doctor _____

6. Has your child been seen or treated for dental problems in the past year?

Yes () No () If yes, list date and treatment _____

7. Does your child have a hearing problem? Yes () No () If yes, please explain

8. Does your child wear glasses? Yes () No () For distance () Reading ()

Constantly () If yes, please list date of last exam by eye doctor _____

9. Is your child being treated for an illness at present? Yes () No () If yes, list the

illness and medicine _____

10. Does your child have any health problems you are concerned about or that the

school should be aware of this year? Yes () No () If yes, please explain _____

11. Has your child had any emotional upsets in the past year? (deaths, divorces,

separations, recent moves, for example) Yes () No () If yes, please explain _____

12. Please list the date of your child's last physical exam and the name of the
doctor. _____

13. Birth History: Premature () If so, how much _____

Please provide a brief explanation of any pregnancy, birth or newborn
complications _____

May the information on this form be shared with teachers as needed for your
child's safety and academic progress? Yes _____ No _____

Parent/Guardian Signature _____

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***PLEASE USE THIS FORM FOR YOUR CHILD'S PRE-SCHOOL PHYSICAL EXAMINATION**

Child's Name _____ Age _____
Height _____ Weight _____
Vision R _____ L _____ With Glasses R _____ L _____
Hearing R _____ L _____ Tubes inserted (date) _____

Body Systems Please explain positive findings below

Heart _____ Blood Pressure _____
Lungs _____
Abdomen _____ Hernia: Yes ___ No ___
Genitals _____
Nervous System _____
Skin _____
Orthopedic _____
Posture _____
Evidence of Scoliosis _____
Feet _____
Head & Scalp _____
Nose _____
Throat _____
Glands _____
Teeth & Mouth _____

Speech _____
Behavioral _____

Please list any: daily medications/dose/time _____

Restrictions, if any _____

Recommendations: _____

PLEASE PROVIDE COPY OF IMMUNIZATION RECORDS

Physician's Signature _____ Date _____