

**WARREN TOWNSHIP SCHOOLS**  
Health History- Elementary Student

Student's Name \_\_\_\_\_ Gr: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Telephone \_\_\_\_\_ Address \_\_\_\_\_

**Physical examinations MUST be submitted for all Students New to the District.** The physical must be completed within 365 days prior to school entry into the district and submitted by the first day of school. Immunization records should be up to date and complete with month, day and year. **The Physical MUST be documented on the Warren Township District Form.**

**The exam MUST be completed by a New Jersey licensed MD or nurse practitioner.**

**Please explain responses on back**

	Yes	No
1.Has been medically advised not to participate in any sport, and the reason for such		
2.Is under a physician's care and the reason for such care		
3.Has experienced loss of consciousness after an injury		
4.Has experienced a fracture or dislocation		
5.Has undergone any surgery		
6.Takes medication on daily basis: name and reasons		
7. <b>Has allergies</b> including bee stings & food allergies? Please List: Medication:		
8.Has experienced frequent chest pains or palpitations		
9.Has a recent history of fatigue or undue tiredness		
10.Has a history of fainting with exercise		
11.Has a history of family member having sudden death		
12.Has a bleeding tendency		
13.Has had rheumatic fever		
14.Has a vision defect: wears glasses, wears contacts		
15.Has a loss or seriously impaired function of a paired organ (eye, ear, testicle, kidney)		
16.Has had a dental checkup by a dentist within the year		
17.If the child had a dental checkup, did the child have cavities		

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date