Wallington, NJ Public Schools
New Student Medical History Questionnaire
(TO BE COMPLETED BY PARENT/GUARDIAN)

Student Name: _____ Date of Birth: _____

Grade: _____ Homeroom: _____ School Year: _____

Last school attended and address_____

Please explain "yes" answers in the space provided with appropriate details.	Yes	No
Has your child been medically advised not to participate in any sport or physical activity?		
Is your child currently or recently under physician's care for any medical reason?		
Has your child ever experienced loss of consciousness after an injury?		
Has your child experienced a fracture or dislocation?		
Has your child had any surgery?		
Does your child take any medications on a regular basis? For what? Will it need to be administered in school?		
Does your child have allergies, including hives, asthma, or reaction to bee stings? Does it require medication?		
Has your child ever experienced frequent chest pains or palpitations?		
Does your child have a history of fatigue or undue tiredness?		
Does your child have a history of fainting with exercise?		
Is there any history of a family member having a sudden death?		
Does your child have any hearing loss, tubes in ears?		
Does your child wear glasses or contact lenses? Reading ____ Distance ____ Boardwork ____ Always ____		
Other medical/physical conditions not listed?		

Parent Signature: _____ Date: _____