Totowa Borough Public Schools

Washington Park School
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Patricia Capitelli
Chief School Administrator

Jennifer Schweighardt
WPS Nurse

July 17, 2022

Dear Parents/ Guardians,

The Totowa Public Schools are requiring a re-verification process for all students entering the 6th grade. This new process is to help keep the students' medical records up to date.
The re-verification process requires the completion and submission of the attached forms, and a complete vaccination record.

The specific supporting document forms can be found at our website:
www.totowa.k12.nj.us under Nurses Corner or on the parent portal.

Families are required to send this information to the Nurse's office via mail or email.
Please be advised, your re-verification forms and supporting documents should be received by August 15, 2022.

Thank you in advance for your cooperation during this process. If you have any questions, please feel free to contact me via email.

Sincerely,

Jennifer Schweighardt

School Nurse, RN, CSN

HEALTH HISTORY

This questionnaire has been developed so that we might better understand your child and meet his/her individual needs. This questionnaire will be kept with your child's school medical records.

Child's Name: _____ Date of Birth: _____

Address: _____ Totowa, NJ Home Phone #: _____

Mother's Name: _____ Father's Name: _____

Child's Physician: _____ Physician Phone #: _____

1. How would you describe your child's general health? ____Excellent _____Good _____Fair _____Frequently ill

2. Has your child ever been hospitalized? _____ Yes _____ No
   If yes, please describe the reason: _____
   _____

3. Has your child ever had a traumatic injury? (Head injury, broken bones, stitches) _____ Yes _____ No
   If yes, please describe: _____

4. Were there any complications at birth? _____

5. Are there any family illnesses which might have an effect on your child? (Diabetes, etc.) _____
   _____

6. Has your child ever had an eye exam? _____. When and results: _____
7. Does your child wear glasses? _____ Yes _____ No

8. Has your child ever had a hearing exam? _____. If yes, results: _____

9. Does your child have any allergies? _____ . What specific things is your child allergic to? _____
   _____

10. Has your child ever had a severe allergic reaction which requires that medication be kept in school?
    _____ Yes _____ No. If yes, explain: _____

11. Has your child ever had Chicken Pox disease? _____ Yes _____ No. If yes, date: _____

12. Has your child ever had the Chicken Pox vaccine (Varivax)? ___ Yes ___ No. If yes, date: _____

13. Please place a check mark next to any of the following medical problems your child has experienced:

_____ convulsions due to high fever
_____ tonsillitis
_____ tonsillectomy
_____ myringotomy
_____ cauterization of nose
_____ strep throat
_____ heart dysfunction
_____ eczema
_____ hay fever
_____ congenital hip
_____ hyperactivity (diagnosed by doctor)
_____ headaches
_____ ear infections
_____ perforated eardrum
_____ fluid in middle ear
_____ bloody nose
_____ asthma
_____ bladder infection
_____ turning in or out of feet
_____ arthritis
_____ coordination difficulties
_____ involuntary urination (day / night)

(PLEASE COMPLETE BOTH SIDES)

14. Please comment on any areas you have checked: _____

_____

_____

15. Does your child have any special fears or anxieties? _____ . If yes, please explain: _____

_____

16. Does your child take any medication on a regular basis? _____ Yes _____ No

Name of medication: _____ Dosage: _____

Prescribing Doctor: _____

Reason for this medication? _____

17. Any additional health/medical information about which we should be aware of? _____

_____

_____

I GIVE MY PERMISSION TO HAVE THE INFORMATION CONTAINED IN THIS HEALTH HISTORY SHARED WITH THE MEMBERS OF THE SCHOOL STAFF WHO ARE RESPONSIBLE FOR MY CHILD.

_____ _____

Parent/Guardian Signature Date

TOTOWA SCHOOLS PHYSICAL EXAM REPORT

Child's Name: _____ Sex: _____ Birthdate: _____

Father's Name: _____ Mother's Name: _____

Date of Physical: _____

Pulse _____ Resp. _____ B/P _____

Height _____ Weight _____

Eyes-Vision	Normal _____	Abnormal_____
Ears-Hearing	Normal _____	Abnormal_____
Nose-Throat	Normal _____	Abnormal_____
Lungs	Normal _____	Abnormal_____
Heart	Normal _____	Abnormal_____
Nutrition	Normal _____	Abnormal_____
Skeletal System	Normal _____	Abnormal_____
Skin	Normal _____	Abnormal_____
Nervous System	Normal _____	Abnormal_____

Disease History

Tuberculosis	Yes _____ - Date _____	No _____
Chicken Pox	Yes _____ - Date _____	No _____
Measles	Yes _____ - Date _____	No _____
AIDS	Yes _____ - Date _____	No _____
Scarlet Fever	Yes _____ - Date _____	No _____
Hepatitis	Yes _____ - Date _____	No _____
Lyme Disease	Yes _____ - Date _____	No _____

Scoliosis: >10 years old. Pos *___ Neg ___ Explain* _____

Allergies that might affect school behavior or attendance _____

_____

Describe any physical condition that might affect student's participation in the school program _____

_____

Does this student take any medication on a regular basis? List medications _____

_____

Has this student ever had a psychiatric exam? Identify reasons and results _____

_____

Has this student ever had a neurological exam? Identify reason and results _____

_____

Rate student's overall health: ____Excellent _____Good ____Fair _____Poor

***Signature of examining physician** _____ **Date:**_____

***OFFICIAL PHYSICIAN STAMP:**

(THIS FORM IS NOT ACCEPTED WITHOUT SIGNATURE & STAMP OF PHYSICIAN)