MONTCLAIR PUBLIC SCHOOLS
Student Health Survey

Student's Name _____ **Date of Birth** _____

Please check and explain any conditions your child may have and return this form to the School Nurse prior to the first day of school.

- ☐ Allergies - Life-Threatening
- ☐ Allergies - Non Life-Threatening
- ☐ Food Intolerances
- ☐ Autism Spectrum
- ☐ Seizure Disorder
- ☐ Routine Medication at school or at home
- ☐ Anxiety and/or Depression
- ☐ Concussion/Head Injury
- ☐ High Blood Pressure
- ☐ Bladder or Bowel Issues (Wets/Soils)
- ☐ Chronic Headaches or Migraines
- ☐ ADD Diagnosis
- ☐ Psychiatric Diagnosis
- ☐ Current or history of Cancer
- ☐ Eyeglasses and/or Contact Lenses
- ☐ Heart Murmur
- ☐ Eczema
- ☐ Sickle Cell Anemia Disease
- ☐ Diabetes
- ☐ Asthma
- ☐ Congenital Abnormalities
- ☐ IEP and/or I&RS
- ☐ 504 Accommodation Plan
- ☐ Hyperactivity
- ☐ Frequent Stomachaches
- ☐ Panic Attacks
- ☐ Scoliosis
- ☐ Frequent Nosebleeds
- ☐ Hearing Aids
- ☐ ADHD Diagnosis
- ☐ History of Surgery
- ☐ Orthopedic Devices
- ☐ Hospitalization
- ☐ Heart Disease
- ☐ Fainting Spells
- ☐ Speech Defect
- ☐ Autoimmune Disorder

Please Explain: _____

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Reminder: TDaP & MCV4 vaccines required for all students who are entering 6th grade and reach age 11.

Reminder: All preschool age children entering a NJ school must receive a flu vaccine every fall.

Parent/Guardian Signature: _____ **Today's Date**: _____