

*Saint Mary School PTA  
30 Elizabeth Street  
Bordentown, NJ 08505*

**SCHOOL NURSE INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Emergency Number \_\_\_\_\_

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Has Child Had:	No	Yes	Date
Scarlet Fever	_____	_____	_____
Chicken Pox	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Pneumonia	_____	_____	_____
Frequent Colds	_____	_____	_____
Frequent Ear Aches	_____	_____	_____
Frequent Sore Throats	_____	_____	_____
Trouble with Hearing	_____	_____	_____
Trouble with Vision	_____	_____	_____
Any Operations	_____	_____	_____

If so, please list procedures here \_\_\_\_\_

Speech defects, problems \_\_\_\_\_

Type of Speech Defect \_\_\_\_\_

Does Your Child Have:	No	Yes	Date
Glasses	_____	_____	_____
Date of last eye exam: _____			
Frequent Vomiting/Diarrhea	_____	_____	_____
Tendency to Bleed Easily	_____	_____	_____
Temper Tantrums/Breath-Holding	_____	_____	_____
Unusual Nervousness, Nail-biting, Thumb-sucking	_____	_____	_____
Difficulty with Toilet Training	_____	_____	_____
Has your child had any severe injuries?	_____	_____	_____

If yes, please explain \_\_\_\_\_

Past Concussions	Yes _____	No _____	How Many? _____
Past Skull Fractures	Yes _____	No _____	
Neck Injury	Yes _____	No _____	
Epilepsy/Convulsive Disorders	Yes _____	No _____	
Chest, Cardiovascular, Abdomen —Any Defects?	Yes _____	No _____	
Any History of Allergies or Asthma?	Yes _____	No _____	
Eczema	Yes _____	No _____	
Rashes	Yes _____	No _____	
Allergic to Medication?	Yes _____	No _____	Which? _____

Last Seen by a Doctor: \_\_\_\_\_ For: \_\_\_\_\_

Medications: \_\_\_\_\_

Please list any information that the school nurse should have on file.

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