



Robert Cannizzaro
 Principal

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Tel: (973) 478-0514 • Fax: (973) 478-7753

Health Assessment

Child's Name: _____ (Nickname) _____

Address: _____

Date of Birth: _____ Right Handed _____ Left Handed _____

Mother's Name _____ Father's Name _____

Did you have a normal birth and delivery? (Y/N) _____ If No Please Explain _____

Premature? _____ Birth Weight? _____

Does your child see a doctor, dentist, and/or psychologist for continuous medical supervision other than a yearly physical? (Y/N) _____

Does your child take medication regularly? (Y/N) _____ If yes what medication and for what reason?

Does your child have asthma? (Y/N) _____ If yes does your child use inhaler/nebulizer? (Y/N) _____

What medication is used to treat your child's asthma? _____

Does your child have any allergies to: Medication? (Y/N) _____ Food? (Y/N) _____ Dust or Pollen? (Y/N) _____

Does your child take any prescribed medication for seasonal allergies? _____

Has your child had any of the following? If so please give month and year in box

	Epilepsy		Strep Throat		Frequent Ear Infections
	Chicken Pox		Scarlet Fever		Bronchitis
	Tonsillitis		Rashes		Congenital Defects
	Asthma		Hepatitis		Convulsions
	Diabetes		Heart Disease		Mononucleosis

Columbus School

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Does your child have any problems with hearing? (Y/N) _____ Speech? (Y/N) _____

How is your child's Appetite? Excellent _____ Good _____ Fair _____ Poor _____

Any special Diet at home? _____ Does your child eat breakfast? _____

Does your child sleep well at night? _____ Does your child have a rest period during the day? (Y/N) _____

Can your child take care of their bathroom needs? (Y/N) _____ If No, what assistance is needed?

Has your child attended nursery school? (Y/N) _____ If yes, where and how long? _____

Has your child ever experienced any sever emotional shock? (Y/N) _____ If so please explain:

Does your child have any strong fears? (Y/N) _____ If so please explain: _____

Should there be any additional matters you would like to share please contact the nurse.

Sincerely,

Ms. Lisa Cangialosi, RN, BSN

School Nurse
973-478-3503

Date: _____

Parent/Guardian Signature