Denville Township Schools
Medical History

To Be Completed by Parent: (PLEASE PRINT)

Child's Name: _____ Sex: _____
Last First Middle
Address: _____ Phone: _____

Family Doctor: _____ Phone: _____

Indicate Date(s) of Any Illness or Child's Age(s) at Onset /Recurrence

Allergies _____ Asthma _____ Otitis Media (ear infections) _____

Drug Sensitivities _____ Chicken Pox _____ Rheumatic Fever _____
Lyme disease _____ Convulsions _____ Strep Infections _____
Hepatitis _____ Diabetes _____ Mononucleosis _____
Pneumonia _____ Heart Disease _____ Other _____

Describe Other Conditions:

Frequent Colds or Sore Throats: _____

Frequent Ear Infections: _____ Tubes: _____

Operations: _____

Serious Injuries: _____

Orthopedic Problems: _____

Allergies to Bees or Other Insects: _____

List Any Other Allergies: _____

Describe allergic reaction: _____

List any Other Conditions or Information That You Would Like to Share With the School Nurse:

Parent Signature _____Date_____

*****You MUST submit dates of required immunizations signed by your physician in order for your child to enter school.**