Newgrange School
An extraordinary place to learn

The Laurel School
of Princeton

Annual Health History

Student: _____ **D.O.B**: _____ **Grade**: _____

1) Does your child have any allergies to medications or foods? ____**yes** ____**no**
   a) If yes, please explain: _____
2) Does your child have active, or a history of asthma/wheezing/reactive airway disease?
   a) _____**yes, (active)** _____**yes, (history of)** _____**no**: if yes, please explain:
   _____
3) Does your child have active, or a history of neurological disease, or seizure disorder?
   a) _____**yes, (active)** _____**yes, (history of)** _____**no**: if yes, please explain: _____
   _____
4) Does your child have a history of major injury, concussion, surgery, or hospitalization?
   a) _____**yes** _____**no**: if yes, please explain: _____
   _____
5) Does your child have any notable eating habits, or foods to avoid?
   a) ____**normal for age**; c) ____**vegetarian**;
   b) ____**allergies** d) ____**irregular** (please explain) _____
6) Does your child wear glasses or contact lenses?
   a) ____**yes, glasses**; ____**yes, contact lenses**; ____**no, no vision impairment**.
7) Does your child experience unusual sleeping patterns, or difficulty sleeping?
   a) _____**yes** _____**no**: if yes, please explain _____
8) Does your child have any limitations or restrictions? _____**yes** _____**no**: if yes, please explain _____
   _____
9) Is your child under the care of a pediatrician for a medical condition? _____**yes** _____**no**: if yes, please explain _____
   a) **Physician Name**: _____ **Phone**: _____
10) Please list any medications, vitamins, or supplements your child is currently taking: _____
   _____

Consent

____ I permit the release of information on this form for confidential use in meetings regarding my child's health and educational needs at Newgrange.

_____ _____ _____ _____

Parent/Guardian Signature Date Nurse Signature Date

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