Montclair Public Schools
DLC Student Health Survey

Student's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Address: _____ Telephone # _____

Please check if your child has the following:

- ☐ **Allergies - life-threatening**
- ☐ **Allergies - non life-threatening**
- ☐ **Anxiety and/or depression**
- ☐ **Asthma**
- ☐ **Bladder or bowel issues (wets/soils)**
- ☐ **Cancer**
- ☐ **Chronic headaches**
- ☐ **Concussion/head injury**
- ☐ **Diabetes**
- ☐ **Diagnosed with ADD**
- ☐ **Eyeglasses or hearing aids**
- ☐ **Food intolerances**
- ☐ **Frequent colds**
- ☐ **Frequent ear infections**
- ☐ **Frequent nosebleeds**
- ☐ **Frequent stomachaches**
- ☐ **High blood pressure**
- ☐ **History of surgery**
- ☐ **Orthopedic problems**
- ☐ **Routine medication at school or at home**
- ☐ **Scoliosis**
- ☐ **Seizure disorder**
- ☐ **Speech problems**

Please explain:

_____

Gestational and Birth History: _____

Developmental History: _____

Emotional/ Behavioral Concerns: _____

Summary of Expected Healthcare Needs at School: _____

Date of Last Physical Exam: _____ Name of Provider: _____

Parent/Guardian Signature: _____

Date: _____

Nurse's Signature: _____ Date: _____

Form must be completed and submitted to the DLC nurse prior to CST evaluation meeting