

**DEMAREST MIDDLE SCHOOL
DEMAREST, NEW JERSEY
FORM #4**

CHILD'S NAME _____ **TEACHER** _____

1. Does your child suffer from motion sickness? _____
If YES, what does your child do to treat it? _____

2. Is your child under medical care at present? _____
Reason _____

3. Are there any physical activities in which your child should not participate?

4. Does your child have any special condition requiring care in regard to the following:
Heart: Yes No **Diabetes:** Yes No **Asthma:** Yes No
Allergies: Yes No _____ **Epilepsy:** Yes No
Feet: Yes No **Operations:** Yes No

5. Are there any requirement(s) including dietary which your child must observe?

Requirement(s): _____

6. Please indicate your child's eating habits:
Good _____ Fair _____ Poor _____

7. Does your child have any of the following sleeping habits?
Nightmares: Yes No **Sleepwalking:** Yes No
Enuresis (bed wetting): Yes No **Disturbed sleep:** Yes No

8. Does your child have a drug allergy? _____ Serum sensitivity? _____

9. Does your child have health insurance? YES _____ No _____
Policy Name: _____ Policy Number: _____

10. Is there anything special that you want to call to the school's attention?

11. Are there any problems or other matters which you would like to discuss with the school staff?
(Principal, teacher, nurse) _____

Date

Parent/Guardian's Signature

*******ALL FORMS MUST BE RETURNED BY WEDNESDAY, MARCH 27TH *******