CLAYTON PUBLIC SCHOOLS

Health History

TO BE COMPLETED BY PARENT/GUARDIAN

Students Name_____ Birthdate_____ Grade____ Age____ Date_____
Emergency Contact 1. (Parent/Guardian) _____ Phone _____ Phone_____
Emergency Contact 2. _____ Phone _____ Phone _____
Emergency Contact 3. _____ Phone _____ Phone _____
Parent/Guardian Email_____

(The emergency contacts above allow the school to speak to them about your child, make pertinent decisions on their behalf and pick your child up from school *if* you are unable to be reached).

Check relevant boxes below. If your child is in need of treatment during school hours, specify the treatment requirement below (***ASTHMA*** *meds, including inhalers & nebulizers,* ***SEIZURE*** *meds and* ***ALLERGY/EMERGENCY*** *meds* require your child's ***HEALTHCARE PROVIDER*** to fill out an ***"ACTION PLAN"***, which can be located on the school's website or provided by the school nurse).

- ☐ Allergies (e.g. foods, animals, seasonal) If so, list treatment requirements and provide Healthcare Providers orders to administer emergency meds, below. *If your child is administered emergency meds of any kind, 911 will be notified to transport your child to the hospital for follow-up care.*
  _____
- ☐ Asthma and/or wheezing_____
- ☐ Diabetes_____
- ☐ Mental and/or Physical disability_____
- ☐ Seizure disorder_____
- ☐ Serious illness/condition past & present_____
- ☐ Surgeries & serious injuries past & present_____
- ☐ Family history of the following *(please circle):* asthma, cancer, diabetes, drug abuse, heart disease, high blood pressure, mental illness, seizures?
- ☐ Wears glasses and/or contacts, continuously or reading only_____

Whenever possible parents/guardians are advised to give medication at home and on a schedule other than school hours. If it is necessary for your child to have medication during school hours, the following instructions must be followed: A Healthcare Provider must ***prescribe*** medication, Parent/Guardian must ***authorize*** medication, and an adult must bring medication to school in its original container with the label intact.

- ☐ I give permission for my child to receive "Over The Counter" medications: Tylenol, Advil, Benadryl, Cough Drops &/or Tums for minor discomforts during school hours, if needed.

TO BE COMPLETED BY HEALTHCARE PROVIDER IF MEDICATION IS NECESSARY TO BE ADMINISTERED TO THIS STUDENT, EITHER ROUTINELY OR PRN, DURING SCHOOL HOURS.

Diagnosis/Condition:_____

Medication	Dose	Route	Time

- ☐ The school nurse or designated trained personnel has my permission to administer the above medication(s) in school and/or on class trips, to the student indicated on this form, for this school year only.
- ☐ The student indicated on this form is capable of carrying and self-administering this medication in school and/or on class trips, has been instructed on the proper procedure, protocol and technique of self-carrying and self-administration and has my endorsement to self-carry and self-administer this medication while in school and/or on class trips, for this school year only.

Healthcare Provider {***Signature***} (stamp below) Date

***Parent/Guardian PLEASE fill out *Insurance Information* on backside of this form.**

TO BE COMPLETED BY PARENT/GUARDIAN

☐ My child has health insurance coverage?

Name of health insurance company_____

☐ If ***NOT***, NJ Family Care provides low-cost or free health insurance for uninsured children and certain low-income families

- For more information call 800-701-0710 or visit www.njfamilycare.org to apply or
- **Physical Exams** may be obtained locally at:

  Complete Care

  335 N. Delsea Dr.

  Glassboro, NJ 08028

  856-863-5720

- **Immunizations** or mantoux tuberculin testing for all Gloucester County residents may be obtained at:

  Gloucester County Health Department

  204 E. Holly Ave.

  Sewell, NJ 08080

  856-218-4101

☐ I give you my permission to release my name and address to NJ Family Care Program to contact me about health insurance

The information on this form is correct, and I give my permission to the school nurse to share pertinent health information regarding my child with essential school personnel, emergency contacts, and my child's healthcare provider, if needed. I acknowledge that the school and school nurses shall incur no liability because of any condition arising from decisions made on behalf of my child and in the best interest of my child's health and welfare. I indemnify and hold harmless the school and its employees or agents against claims arising from the decisions made on behalf of my child and in the best interest of my child's health and welfare.

Healthy Regards,
Michele Avallone (ES), RN, BSN, CSN
Julie Kosylo (ES), RN, BSN, CSN
Sherry L. Richards (MS & HS), RN, BSN, CSN

Parent/Guardian ***{Signature}*** Date

This form is good for **ONE school year! Updated 6/5/17*