



Clayton Public Schools

MIDDLE and HIGH SCHOOL Required Annual Health History Update

Both sides of this form are to be completed by the parent/guardian:

Student Address _____

Parent/Guardian Name _____ Home Phone _____ Work Phone _____

Parent/Guardian Name _____ Home Phone _____ Work Phone _____

Emergency Contacts: Please list three persons we may call if you cannot be reached in the event of an emergency or if your child needs to be picked up from school.

1. Name _____ Relationship _____ Daytime Phone _____

2. Name _____ Relationship _____ Daytime Phone _____

Medical Update: Please check conditions that are either new or still applicable to your child:

_____ *Asthma and/or wheezing

My child may require an asthma inhaler or nebulizer treatment during the school day. Circle: Yes or No

*Asthma medications, including nebulizers or inhalers require an **Asthma Action Plan** to be completed by your physician. A new one is required each school year. This form is available on the district website under district information: school nurses/health office.

_____ *Food Allergies _____ *Environmental Allergies

My child's specific allergies are: _____

My child's food and/or environmental allergy requires an Epi Pen or Epi Pen Jr. Circle: Yes or No

*Students with severe allergies requiring Epi Pens require an **Allergy Action Plan** to be completed by your physician and signed by the parent/guardian. A new one is required each school year. This form is available on the district website under district information: school nurses/health office.

_____ *Seizures

My child's last known seizure was on _____

_____ If your child has Emergency Seizure medications, please list: _____

*Students with a history of seizures require a **Seizure Action** plan to be completed by your physician and signed by the parent/guardian. A new one is required each school year. This form is available on the district website under district information: school nurses/health office.

_____ *Diabetes

*Students with diabetes require a **Diabetes Action Plan** to be completed by your physician. A new one is required each school year. This form is available on the district website under district information: school nurses/health office.

_____ *ADHD, ADD, ODD, OCD

The name of my child's medication is: _____ Dose _____ mg

_____ My child requires this medication to be given at school. Circle: Yes or No

*Students requiring any type of medication at school must have a **Medication Consent Form** completed by your physician and signed by the parent/guardian. A new one is required each year. This form is available on the district website under district information: school nurses/health office.

This form is to be completed by the parent/guardian:

Insurance Information: My student has health insurance coverage. Circle: Yes or No

If yes, please provide name of health insurance company: _____

Physician Name _____ Physician Phone _____

If no, NJ FAMILY CARE provides low-cost or free health insurance for uninsured children in 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 Medical Professionals
Collegetown Shopping Center
715 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 the NJ Family Care Program to contact me about health insurance.

Over-the-Counter Parental Permission:

To treat your child for minor discomfort and keep them as comfortable as possible during school hours, without disrupting their education, please complete this section if you would like your child to have the over-the-counter medications listed below. Please check:

- _____ My child has NO KNOWN DRUG allergies.
- _____ My child has NO KNOWN FOOD allergies.
- _____ My child is allergic to the following medications: _____

_____ **YES, I give permission for my child to have the specific over-the-counter medications listed below:**

For muscle aches, headaches, menstrual cramps, or other minor discomforts:

- _____ Tylenol (acetaminophen) per package dosing based on age/weight
- _____ Advil/Motrin (ibuprofen) per package dosing based on age/weight

For upset stomach, indigestion:

_____ Tums

For cough, sore/scratchy throat:

_____ Cough Drop

For ALLERGIC REACTIONS only:

_____ Benadryl (diphenhydramine) per package dosing based on age/weight

_____ **NO, I DO NOT give permission for my child to have the medications listed above during school hours.**

_____ **Specific instructions from parent, if any:** _____

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,

Sherry L. Richards, BSN, RN, CSN-NJ (MS & HS) srichards@claytonps.org

Feel free to email your school nurse at any time. We are dedicated to the health and safety of your child.

Signature of Parent/Guardian

Printed Parent/Guardian Name

Date

This form must be completed and signed annually.