Student Name _____ Grade____ Teacher/HR_____
Date of Birth _____ School Year _____

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 two 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 RN, BSN, 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.