COMMERCIAL TOWNSHIP SCHOOL DISTRICT
Haleyville-Mauricetown School
Student Health Assessment Record
School Year 2020-2021

Dear Parent/Guardian,
In order for the school nurse to have the most current health information on your student and to help your student have a healthy and successful year, please complete and return this form to the teacher or school nurse. The purpose of this form is to provide the school nurse with additional and updated information regarding your child's health needs. The school nurse may contact you for further Information. Thank you for your cooperation.

To Be Completed By Parent/Guardian & Returned To The School Nurse

Name of Student (Last, First, Middle)	Date of Birth	Grade	Teacher

Name of Parent(s)/Guardian(s)	Student's Address (Street)	City

Home Phone#	Mother's/Guardian's Cell Phone	Mother's/Guardian's Work Phone	Mother's/Guardian's Email Address

Father's/Guardian's Cell Phone#	Father's/Guardian's Work Phone#	Father's/Guardian's Email Address

Part I – Health Information

Place where your child receives Health care:

Date of last eye exam:_____

Private Physician
Health Department
Hospital ER
Other _____
No regular physician

Physician's Name:
_____

Date of last physical:_____

Place where your child receives Dental care:

Private Dentist
Dental Trailer/Tooth Mobile
Smile/Smart Program
Other _____
No regular dentist

Dentist's Name:
_____

Date of last dental visit:_____

Type of Insurance your child has:

Private Insurance
Medicaid
NJ FamilyCare
No Insurance
Other: _____

Eye Doctor's Name:
_____

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Authorizations:

I give my permission for the school nurse to share or receive health-related information needed to care for my above-named child with other healthcare providers (doctors, specialists, case managers) during the 2020-2021 school year. This may include medical conditions, immunizations, medication administration or in an emergency.

I authorize the school nurse to discuss allergies, medical conditions and/or medications as needed with the school personnel having direct contact with my child.

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

_____ **YES, My child has health insurance**

_____ **No, My child does not have health insurance**

Does your child have **dental** insurance? Yes No
Does your child have **vision** insurance? Yes No

Part II – Medical History

NO KNOWN HEALTH PROBLEMS
(If no, please go directly to the bottom of the page and provide parent/guardian signature.)

Attention Deficit Disorder (ADD) OR **Attention Deficit Hyperactivity Disorder (ADHD)**	Requires medication? If yes: name & dose: _____ To be given at school?(Requires written order from physician)
Allergies: Please Specify ○ **Food** _____ ○ **Insects or Animal** _____ **Seasonal** _____ ○ **Medications** _____	Hives/rash? Breathing difficulty? Will **Benadryl** be needed in school? (written order from physician) Will **EPIPEN** be needed in school? (written order from physician)
Asthma	He/she uses an inhaler/nebulizer at home? He/she uses an inhaler/nebulizer at school? (Requires written asthma action plan from physician)
Bleeding Problems: **(Hemophilia, Von Willebrand's, frequent nosebleeds)**	Requires medication? Please explain: (Requires written order from physician)
Dental Problems:	Braces? OR Please explain:
Diabetes: (Requires medication & written orders from physician) ○ **Type 1 Diabetic** ○ **Type 2 Diabetic**	Monitors blood sugars while at school? Requires insulin at school? Glucagon order? Insulin Pump? Managed with diet?
Eating Disorder: Please explain:	
Emotional/Behavioral/Psychological: Please explain:	
Gastrointestinal/Stomach Problems: Please explain:	
Headaches: Please explain:	Medication required? _____
Hearing Problems:	Right Ear ☐ Left Ear ☐ Both Ears ☐ Hearing loss? ☐ Hearing aid? ☐ Tubes?
Heart Condition: Please explain: Are there any activity restrictions? Any medications taken at home?	

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Hypertension (High Blood Pressure):

Juvenile Arthritis/Bone-Joint Problems: Please explain:

Kidney Problems: Please explain:

Menstrual Problems: Please explain:

No treatment Wears Brace Surgery

Type of seizure: _____

Diastat Order (Requires written order from physician)

Special Diet: Please explain:

Vision Problems: Wears glasses Wears contacts Other: _____

Other Medical Conditions/Surgeries: Please include **any** medications taken at home only:

Required Signatures

Signature of parent/guardian: _____ **Date:** _____

Reviewed by School Nurse: _____ **Date:** _____

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