Collier Youth Services

160 Conover Rd.
Wickatunk, NJ 07765
732-946-7832 ext. 312 Fax 732-837-1420

Student Health History

Student's Name: _____ Birth Date: _____Gender:_____
Address:_____ Home Phone: ( )_____
Physician's Name:_____ Phone: ( )_____
Emergency Contact Name:_____ Phone: ( )_____

Dear Parent/Guardian:
We would like for your child to gain the most from his/her school experience. To accomplish this it is necessary to have a current health history, please answer the following questions:

Allergies Yes ____ No ____ Type _____
Reaction _____ treatment/medication _____
Asthma Yes _____ No _____ medication_____
Chicken Pox Yes ____ No ____ Date _____
Concussion/head injury Yes ____ No ____ Date _____
Diabetes Yes ____ No ____
Gastrointestinal Yes ____ No ____
Nutritional/Eating problems Yes ____ No ____
Kidney/bladder condition Yes ____ No ____

Ear Problems Yes____ No____
Specify_____
Eye Problems Yes ____ No____
Does he/she wear contact lenses? Yes ____ No ____
Does he/she wear glasses? Yes ____ No ____
Headaches Yes ____ No ____
Heart Disease/Murmur/ Yes ____ No ____
Abnormal EKG Yes_____ No_____
Muscle or Bone disorder Yes ____ No ____
Speech Problems Yes ____ No ____

Epilepsy/seizures Yes ____ No ____ Type_____ Date of last _____Medication _____

Does your child take any medications on a regular basis? Yes ____ No ____ If yes please list name, dosage and directions: _____
_____
Has your child ever had surgery? Yes ____ No ____ If yes, please explain: _____
_____
Has your child ever been hospitalized? Yes ____ No ____ If yes, please explain:_____
_____
Is there anything more about your child's health that you think is important for us to know? Yes ____ No ____
If yes, please explain: _____

I/we give permission for the nurse to share this information with the principal, social workers and teachers on a "need to know" basis. Please be assured that any information of a confidential nature will be treated with respect.

Parent/Guardian's Signature: _____ Date: _____

Please provide a copy of student's immunization records. Please do your best to keep us updated on student's medication changes, as well as new immunizations received. If the student needs to take medication in school please provide orders from the prescribing doctor along with the medication in its original container. If the medication is an inhaler please provide ASTHMA ACTION PLAN or an epi pen please provide an ALLERGY ACTION PLAN (both forms filled out and signed by a doctor). If you have any questions feel free to call the health office at ext. 312.