NORTHERN HIGHLANDS REGIONAL HIGH SCHOOL

CONFIDENTIAL MEDICAL INFORMATION

Name:_____Grade:_____

Date registered: _____Starting Date:_____

Physician Name_____Physician Phone Number:_____

Check any conditions below that are applicable:	**IF YES, please provide more specific information, if necessary:**
[ ] Life-Threatening Allergy	
[ ] Asthma	
[ ] Diabetes	
[ ] Food Allergy	
[ ] Food Restrictions	
[ ] Non-Life-Threatening Allergy	
[ ] Convulsive Disorder	
[ ] Heart Disease	
[ ] Headaches	
[ ] Hearing Problem	
[ ] Seasonal Allergies	
[ ] Lyme Disease	
[ ] Neuromuscular Disease	
[ ] Vision Problem	
Other:	

Comments:

In case of accident or serious illness, I request the school nurse to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated above and to follow their instructions. If it is impossible to contact my child's physician, the school may contact any of the emergency contacts on record and make whatever medical arrangements are necessary. While the school attempts to contact the above persons, the school will provide immediate triage and contact emergency medical services/the rescue squad when deemed necessary. This permission applies to the entire period my child is enrolled at Northern Highlands.

Health screenings will be conducted by the School Nurse when a current physical exam containing that health information is not on file in the health office. Screenings for height, weight, blood pressure, vision, hearing and scoliosis will be conducted as per New Jersey State Code (N.J.A.C. 6A: 16-2-2)

Signature of parent or guardian: _____

Date: _____

Cc: School Nurse