MOUNT ARLINGTON PUBLIC SCHOOL DISTRICT
OFFICE OF THE PRINCIPAL
235 Howard Boulevard
Mount Arlington, New Jersey 07856
Telephone (973) 398-4400 Fax (973) 398-5726

ANNUAL MEDICAL UPDATE FORM

Student's Name: _____ Age: _____ Grade: _____

Does your child have asthma as diagnosed by a physician? Yes: _____ No: _____

Has your child had any reactions to medications, foods, or insects? Yes: _____ No: _____

If yes, please list type of reaction and care required: _____

_____

_____

Does your child take any medications? Yes: _____ No: _____

If yes, please indicate medication, amount, and time of administration: _____

_____

_____

Please list any illnesses, injuries, operations, immunizations, etc. your child has had in the past year (include exact dates): _____

_____

Does your child wear glasses? Yes: _____ No: _____ Contacts? Yes: _____ No: _____

If yes, is the correction for near vision? _____ or distance vision? _____

Please list any other health concerns you have for your child: _____

_____

_____

****I give permission for the School Nurse to inform the appropriate staff members of my child's medical condition(s) or special need(s).** Yes: _____ No: _____

Parent/Guardian Signature:_____ Date:_____