

Long Beach Island Consolidated School District

Health Information



Barneget Light Harvey Cedars Surf City Ship Bottom Long Beach Township

Student Name \_\_\_\_\_ Date: \_\_\_\_\_

1. If your child has any health conditions or concerns, please explain below. Be sure to include any medical/surgical care your child has received during the past year.

\_\_\_\_\_  
\_\_\_\_\_

2. Is your child prescribed any medication for:

Asthma  Diabetes  Allergies  Seizures  Other \_\_\_\_\_

My child will need medications while at school

Please provide additional detail if your child has been diagnosed with an allergy that requires the use of an EpiPen for emergencies:

Allergies (Be Specific) \_\_\_\_\_

Type of Reaction \_\_\_\_\_

Please provide additional detail if your child has been diagnosed with asthma:

Specific Trigger/Allergen(s) \_\_\_\_\_

The district’s Medication Authorization forms, Asthma Action Plan, Food Allergy Action Plan, Seizure Action Plan and Diabetes Medical Management Plan can be printed from the school’s web page under the STUDENT HEALTH tab.

3. Does your child have any physical limitations or restrictions?

Heart Condition  Physical Handicap  Recent Surgeries  Glasses  Contacts  Hearing Loss

A Cardiac Condition requires physician documentation of condition and limitations detailed.

\_\_\_\_\_  
\_\_\_\_\_

4. Does this child have Health Insurance?

Yes \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_

No \_\_\_\_\_ NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit [www.njfamilycare.org](http://www.njfamilycare.org) to apply.

School may release my contact information to NJ FamilyCare for health insurance material.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

5. I permit necessary health records and I.E.P. reports regarding my child to be shared with certified staff members, confidential secretaries and administrators on a “need-to-know” basis.

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Physician/Dentist Information:

Family Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

If emergency treatment is required and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school authorities to exercise their own judgment in calling the physician indicated above, or if not available, to transport the child to a hospital emergency room.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_