Mt. Olive Township Public Schools
Student Medical History Update (parent to complete)

Student Name: _____ DOB:_____

School:_____ Grade/Teacher:_____ School Year:_____

Concerns	Yes	No	Complete- If Yes
Allergic to: Bee Stings			Epi-Pen Yes No
Allergic to: Medications			List:
Allergic to: Foods			List Food and reaction: Epi-Pen Yes No
Any medications taken at home (dose, times)?			
Asthma			Medications:
Seasonal Allergies			Medications:
Attention Deficit			Medications: Hyperactivity: Yes No
COVID-19			Date:
Headaches			Medications:
Migraines			Medications: Symptoms:
Stomach Problems			
Hearing Problems			Hearing Aids: Yes No
Visual conditions			Glasses: Yes No Last Eye Exam:_____
Diabetes			Pump: Yes No
Cardiac/Heart conditions			Medications:
Seizures:			Medications: Date of last seizure
Behavior/emotional concerns			
Other General health/ medical concerns (eating/ sleep habits, posture, teeth, skin, menstruation, weight, COVID-19 history)			

Please return to the Health Office School Year 2024-2025

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SCHOOL HEALTH ROUTINES AND SCREENINGS

- **Cough drops, Tylenol, Motrin, and all medications (this includes over the counter and prescription medications except those listed below) require a physician's order to be administered in school. Please see the Health Office website, and download forms if you wish your child to have any medication in school.**
- Height, weight and blood pressure, and hearing screenings are conducted on all student's preschool through 5th grade **as mandated by NJ State Law.**
- Vision screening is conducted on all kindergarten, 2nd and 4th grade students **as mandated by NJ State Law** for those students who have not submitted a private examination.
- If your child is in the 5th grade, scoliosis is required by NJ State law. If you would like your child to be excluded from this screening, please sign here: _. Copies of private physician examinations for scoliosis are due by June, 2025.
- **Please note that additional immunizations of Tdap and Meningococcal vaccine will be required for entrance to 6th grade.**

PERMISSIONS:

Do you give permission to share the aforementioned information with appropriate faculty and staff who work directly with your child? This information will be handled confidentially. **YES NO (circle)**

Health Care Practitioners/Specialists Information:

Practitioner Name	Practitioner Phone Number

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) named as emergency contacts, and do authorize the named physicians to render such treatment as may be deemed in an emergency, for the health of said child. In the event that physicians, emergency contacts, or parents/guardians cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Student Name: _____

Parent/Guardian Signature: Date: _____