# CHERRY HILL PUBLIC SCHOOLS

***School Nurse Health Record Summary***

Student's Name_____ Date of Birth_____

Grade_____ Homeroom Teacher/Team/LC _____ Date_____

1. Does your child take medication(s) on a regular basis (at home or school)? *Yes*_____ *No*_____

   If yes, please list medication(s) and reason(s) for medication(s):
   _____

2. Has your child had any accidents, injuries, operations, or serious illness over the past year? *Yes*_____*No*_____
   If yes, please explain:
   _____

3. Does your child have any allergies and/or chronic health issues? *Yes*_____*No*_____
   If yes, please explain:
   _____

4. Has your child had any vaccinations in the past year? *Yes*_____*No*_____
   If yes, please list the vaccinations and provide documentation from your child's doctor or advanced practice nurse:
   _____

5. Have there been any other changes in your child's health status? *Yes*_____ *No*_____
   If yes, please explain:
   _____

6. Name and phone number of student's primary health care provider:
   _____

7. Name and phone number of student's dentist:
   _____

8. Preferred Hospital (transport squad determines the hospital):
   _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons named on this card, or parents 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. Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

**Yes**_____ If Yes, name of insurance company: _____

**No** _____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents.
For more information call 1(800)701-0710 or visit www.njfamilycare.org to apply online.

If No, you may release my name and address to the NJ FamilyCare Program to contact me about health insurance. *Yes*____ *No*____

**Parent/Guardian Signature: _____ Date:_____**

**Parent/Guardian Printed Name: _____ Date: _____**

*Revised 5/2020*

**COMPLETE BOTH SIDES**

**CHERRY HILL PUBLIC SCHOOLS**
**Emergency Contact Information**

**Student information:**

| Student's last name | Student's first name | Date of birth | Teacher/Grade |
|---|---|---|---|

| Street address | Home phone |
|---|---|

**Parent/Guardian Information:**

| Name | Relationship | Work Phone | Cell Phone |
|---|---|---|---|
| Name | Relationship | Work Phone | Cell Phone |

**Student's Siblings in ANY Cherry Hill Public School:**

| Sibling's last name | Sibling's first name | School/grade |
|---|---|---|
| Sibling's last name | Sibling's first name | School/grade |
| Sibling's last name | Sibling's first name | School/grade |

***if you need more room, please attach a separate sheet of paper

**Emergency Contact Information:**
List two nearby neighbors or relatives who would assume responsibility for your child if we cannot reach you:

| Name | Relationship | Address | Phone |
|---|---|---|---|
| Name | Relationship | Address | Phone |

**Additional Information:**
Please indicate any priority order for calling parent/guardian and emergency contacts or any other information you feel necessary:



**COMPLETE BOTH SIDES**