

Plumsted Township School District

Health Offices

New Egypt High School DGHWES New Egypt Primary School

Telephone: 609-758-6800

Health Update Form

STUDENT INFORMATION

Student Name: _____ DOB: _____

Gender: Male _____ Female _____ Grade: _____

FAMILY INFORMATION

Parent/Guardian Name and Contact Number: _____

Parent/Guardian Name and contact Number: _____

Siblings (Gender and Age): _____

Total number of people living in the household: _____

MEDICAL HISTORY

Does student take medication daily or as needed at home? If yes, please list including dosage: _____

Does student have any of the following:

Asthma _____ Heart Disease _____ History of Seizures _____

Frequent Nosebleeds _____ Diabetes _____ Seasonal Allergies _____

Wear Glasses _____ Hearing Difficulty _____ Mental Health _____

Frequent Headaches _____ Migraines _____ History of Concussion _____

Does your child have any allergies (food, drug, seasonal)? Yes ___ No ___ If yes, please list:

Has your child been prescribed an epi-pen? Yes ___ No ___

Has your child ever required epi-pen injection? Yes ___ No ___

Please list any new/recent injuries, illnesses, surgeries or hospitalizations and age occurred:

Any other comments or concerns about your child's health or change in health:

MEDICAL PROVIDER INFORMATION

Primary Physician Name: _____

Primary Physician Phone Number: _____

Please sign if you give the school nurse permission to provide health information to and receive health information from your child's physician:

Parent Signature

Date

Dentist Name and Phone Number:

Child's Health Insurance: Private Insurance/Employee Sponsored _____ NJ Family Care _____

Other _____ None _____

Would you like assistance finding a healthcare provider? Yes _____ No _____

Would you like assistance obtaining healthcare insurance? Yes _____ No _____

Check here if you want to discuss confidential information with the nurse _____

****The State of New Jersey requires that all children age 10-18 be screened every other year for scoliosis (curvature of the spine).**

___ I want my child screened for scoliosis at school

___ I wish to be present when my child is screened for Scoliosis

___ My child will be screened for scoliosis by our private physician and report will be provided to the school

Parent Signature

Date