

Colts Neck Township Schools

Health History

To be completed by Parent/Guardian:

Name of student: _____ Male ☐ Female ☐
 Student's date of birth: _____ Entering Grade _____
 Mother's first and last name: _____
 Father's first and last name: _____
 Address: _____ Home Phone #: _____
 Pediatrician's name: _____ Phone #: _____
 Medical History: _____
 Allergies: _____
 Medications: _____

****Please note that if medication is required during school hours, you must provide a physician's order and written parent/guardian permission. Forms are available on Health Office web page, or from your child's school nurse.**

Vision or Hearing Problem(s): _____
 Glasses/ contact lenses: _____ Dental Appliances: _____

Please check any health concerns that pertain below. Please explain checked items on an attached sheet or in the medical history section.

Chicken Pox	Fainting Spells	Hepatitis
Bladder/ Kidney	Mononucleosis	Migraines
Congenital Defects	Otitis Media	Heart Disease
Rheumatic Fever	Neuromuscular Disorder	Arthritis
Asthma	Strep Infections	Diabetes
Convulsions/ Seizures	Lyme Disease	High Blood Pressure
Drug Sensitivities		

Please provide detailed information regarding any of the following:

History of excessive bleeding? _____
 Serious injuries or surgical procedures? _____
 Speech/ language concerns? _____
 Learning or behavioral concerns? _____
 Restrictions that may affect the student's participation in school activities/ physical education? _____
 Significant developmental delays? _____

Permission to: Remove tick if able: yes no. To give saltine crackers: yes no

I understand that medical information will be shared with people in the school who need to know. In case of emergency, if unable to contact parent/guardian, I give permission for authorized hospital personnel to provide necessary emergency care for my child.

Parent/ Guardian signature: _____ Date: _____

HEALTH INSURANCE INFORMATION: Do you have health insurance? Y or N

Name of Health Insurance Provider: _____

If you are uninsured and do not have medical insurance, would you like the district to release your information to NJ FamilyCare? Y or N

Please return this form when you register your child.

Revised 2/24/2015