

HEALTH HISTORY

Student Name _____

Grade _____

Date of Birth _____

Age _____

Sex: Male Female

Does your child have any of the following:

	No	Yes	
Allergy: <ul style="list-style-type: none"> • Bee Sting • Food • Medication Epinephrine Ordered by Doctor			bee sting reaction: _____ food & reaction: _____ medication & reaction: _____ 📄 AllergyEmergencyTreatmentPacket
Allergies: Hayfever/Seasonal			season & symptoms: _____
ADD/ADHD			
Anemia			
Asthma			mild____ severe____ 📄 AsthmaActionTreatmentPlan.pdf - required by N.J. law
Behavioral Issues			
Broken Bone History			
Cardiac Condition			
Chronic Constipation			
Developmental Delay			
Dental Problems			
Diabetes			
Eczema			
Fainting Spells			
Frequent Ear Infections <ul style="list-style-type: none"> • Earaches • Hearing Loss • Tubes in Ears 			
Headaches			
Muscle Problems			
Nosebleeds			
Physical Handicap			
Premature or Low Birth Weight			
Seizures/Epilepsy/Tics			
Speech Difficulty or Delay			
Stomachaches			
Vision problem <ul style="list-style-type: none"> • Color Deficiency • Corrective Lenses • Patch 			type of corrective lens? _____ right____ left____

Has your child had any of the following:

Illness	No	Yes	Date(s) of Illness
Chickenpox			
Measles			
Mumps			
German Measles			
Lyme Disease			
Strep. Infection			
Scarlet Fever			
Rheumatic Fever			
Pneumonia			
Hepatitis (type)			
Mononucleosis			

Student Name _____ Date of Birth _____

Is your child currently receiving daily medication?

NO YES

- If YES, please give name of medication, amount and reason: _____
- Will your child require the medication during school hours? NO YES

[Prescription/NonPrescriptionMedicationForm](#) must be completed by parent and doctor for any medication, including over the counter medication, which needs to be given during school hours.

Was a health problem and/or handicap present at birth?

NO YES

- At what age was diagnosis made? _____
Diagnosis: _____

List any operations, injuries or hospitalizations and dates:

Operations/Injuries/Hospitalizations

Date

_____	_____
_____	_____
_____	_____

- Do any of the conditions still affect your child? NO YES
- If YES, please list _____
- Physical Ed Activity: Does condition restrict his/her activities? NO YES

Do you have any concerns about your child's health? If so, please describe _____

I give permission for health concerns to be shared with appropriate staff having contact with my child.

YES NO

Routine screenings are performed, in the Audubon Public schools, by certified school nurses as part of a comprehensive health program required by New Jersey law. Pupils can be exempted from screenings with a written request from the parent/guardian.

Authorization for Medical Treatment

I/We, the undersigned, do hereby authorize officials of the Audubon School District to contact directly the persons named on the "EMERGENCY CONTACT INFORMATION" and do authorize the appropriate school personnel to render first aid as may be deemed necessary in an emergency, for the health of the said child. Pertinent medical information may be shared with school personnel as needed.

In the event that parents or other persons named on the "EMERGENCY CONTACT INFORMATION" cannot be contacted, the school officials are hereby authorized to take whatever action necessary in their judgment, for the health of aforesaid child, including transportation to the nearest medical emergency facility.

I will not hold the Audubon School District financially responsible for the emergency care and/or transportation for said child.

Name of Child's Doctor: _____ Telephone # _____

Date of Last Medical Exam: _____

Name of Child's Dentist: _____ Telephone # _____

Date of Last Dental Exam: _____

Health Insurance Information: Does your child have health insurance?

YES _____ Name of Insurance: _____
 Name of Subscriber: _____
 I.D. Number: _____
 Group Number: _____

NO _____ Do you want Medicaid/NJ Family Care to contact you about free or low-cost health insurance? No _____ Yes _____

Parent/Guardian Printed Name _____ Signature _____ Date _____

Parent/Guardian Printed Name _____ Signature _____ Date _____