Haddon Township Public Schools Annual Health History Update

Dear Parent/Guardian,
This form lists medical conditions that your son/daughter may have experienced in the past year or currently experiences. The updated information enables the Health Office to respond in case of an emergency. Thank you.

1. Has the student been under the care of a physician for any medical conditions? Yes No
   If yes, please explain: _____
   _____

2. Has the student been advised not to participate in any activity or sports? Yes No
   If yes, please explain: _____
   _____

3. Has the student had any major illness since his/her last medical exam? Yes No
   If yes, please explain: _____
   _____

4. Has the student been hospitalized since his/her last medical exam? Yes No
   If yes, please explain: _____
   _____

5. Has the student had any injury or surgery since his/her last medical exam? Yes No
   If yes, please explain: _____
   _____

6. Has the student had any special test such as x-rays, bone scan, EKG, CT, MRI, etc? Yes No
   If yes, please explain: _____

7. Is the student currently taking any medication on a regular basis?: Yes No
   _____

8. Does the student have Asthma or Allergies (medications, foods, bee stings, etc): Yes No
   If yes, please list and explain (Use of inhaler, Epi Pen, etc.)_____
   _____

____Yes, you have my permission to share this information with appropriate faculty/staff members.

____ No, please do not share this information.

Student Name: _____ Grade: _____

Parent/Guardian Signature: _____ Date: _____

Does your child have Health Insurance?

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 800-701-0710 or visit www.njfamilycare.org to apply online.

You may release my name & address to NJ FamilyCare Program to contact me about health insurance.

_____ _____ _____

Signature Printed Name Date

Written consent required pursuant to 20 U.S.C.§1232 g (b)(1) and 34 C.F.R. 99.30 (b).

List any medical/surgical care your child has received during the past year:

Dental Exam _____ _____

date braces

Eye Exam _____ _____

date contacts glasses

Allergy _____ _____

kind medications

Allergic Reactions _____ _____

date medications

Immunizations/Tetanus _____ _____

date type

Restrictions _____

type

Doctor _____ Telephone _____

Dentist _____ Telephone _____

Hospital _____ Telephone _____

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 of said child.

_____ _____

Signature of Parent(s) / Guardian(s) Date