

Burlington County Special Services School District

Student Health History

Name: _____
Last First

DOB: _____

Does the student have or have a history of?

Explain yes answers

Allergies (food/medicine)	<input type="radio"/> Yes	<input type="radio"/> No
Bee Sting Reaction/Epinephrine	<input type="radio"/> Yes	<input type="radio"/> No
Asthma	<input type="radio"/> Yes	<input type="radio"/> No
Diabetes	<input type="radio"/> Yes	<input type="radio"/> No
Epilepsy/Seizures	<input type="radio"/> Yes	<input type="radio"/> No
Heart Condition	<input type="radio"/> Yes	<input type="radio"/> No
Bone/Joint Problems	<input type="radio"/> Yes	<input type="radio"/> No
Glasses/Contacts	<input type="radio"/> Yes	<input type="radio"/> No
Hearing Aides/Tubes	<input type="radio"/> Yes	<input type="radio"/> No
Eating/GI Disorders	<input type="radio"/> Yes	<input type="radio"/> No
Hospitalizations/Surgery	<input type="radio"/> Yes	<input type="radio"/> No
Drug/Alcohol Use	<input type="radio"/> Yes	<input type="radio"/> No
Bowel/Bladder Problems	<input type="radio"/> Yes	<input type="radio"/> No
Psychological Conditions	<input type="radio"/> Yes	<input type="radio"/> No

List Current Medications, Dosages and Times: _____

Please check if you give parental permission for school nurse to administer in school:

(Based on School Physician's standing orders)

____ Throat Spray/Lozenges	____ Antacid (Gelusil, Tums)	____ QR powder to stop nosebleeds
____ Acetaminophen (Tylenol)	____ Sunscreen	
____ Ibuprofen (age 12 or older)		

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

☐ **NO** My child **does not** have health insurance. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: _____ Printed Name: _____ Date: _____

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

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710.

☐ **YES** My child has health insurance.

I hereby authorize school medical personnel to share the above information on a "need to know" basis with any Burlington County Special Services staff that will be in direct contact with my child, i.e. classroom teacher, sports coaches, band director, etc. I understand that school medical personnel will perform mandated health screenings including scoliosis screening. I give permission for school medical personnel to contact my child's physician regarding health concerns.

Parent/ Guardian Signature

Date

Primary Emergency Phone (____) _____ Primary Emergency Email _____