Burlington County Special Services School District

Student Health History and Emergency Card for SY 2019-2020

Student Name: _____ _____ Date of Birth: _____
Last First

Student's Address_____
City State Zip

Home Phone (____) _____ Primary Emergency Phone (_____) _____

Primary Email Address_____

Mother/Guardian_____ Employer_____

Work Phone (_____) _____ Home (_____) _____ Cell (_____) _____

Father/Guardian_____ Employer_____

Work Phone (_____) _____ Home (_____) _____Cell (_____) _____

Group Home Guardian _____Cell (_____) _____

Relative or friend to be notified if Guardian cannot be reached:

1._____ _____ (____) _____ (____) _____
Name Relationship Home Phone Cell

1._____ _____ (____) _____ (____) _____
Name Relationship Home Phone Cell

Does the student have?			**Explain Yes answers:**
Allergies (food/medicine)	Yes	No	What type reaction_____
Bee Sting Reaction/Epinephrine	Yes	No	What type reaction_____
Asthma	Yes	No	Emergency meds Yes No
Diabetes	Yes	No	_____
Epilepsy/Seizures	Yes	No	Emergency meds Yes No
Heart Condition	Yes	No	_____
Glasses/Contacts	Yes	No	_____
Hearing Aides/Tubes	Yes	No	_____
Eating/GI Disorders	Yes	No	_____
Psychological Conditions	Yes	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)

_____Ibuprofen (Advil) _____ Antacid (Gelusil, Tums) _____QR powder to stop nosebleeds
_____Acetaminophen (Tylenol) _____Sunscreen

If we cannot be reached at the time of an emergency, and immediate treatment is necessary, we give permission to send our child (properly accompanied) to the hospital most accessible. We authorize said hospital to institute necessary emergency care. I authorize school medical personnel to share the above information on a "need to know" basis with BCSSSD staff that have direct contact with my child.

I understand that school medical personnel will perform mandated health screenings including scoliosis screening. My child has medical insurance. ___Yes Name of Insurer: _____
*____No My child **DOES NOT** have insurance. You may release my name and address to the NJ Family Care program to contact me about health insurance.*

_____ _____
Parent/ Guardian Signature: ***Date:***