EAST WINDSOR PUBLIC SCHOOLS

Health History Update

2023-2024

Name: ____ Date of Birth:__________ Grade: ________
(Last Name) (First Name) (Middle Name)

Address: ____

Please complete the following health history form and return it to the school nurse as soon as possible.

Date of last physical exam________Physician's name:__________________ Tel #: ____________

Date of last dental exam_______Dentist's name: _____________________Tel #:____________

Health Ins. Co_______________________________Dental Ins. Co.__________________

1.) **Allergies** (i.e. foods, insects, medications) ____________________________________

If your child has food allergies and you pack his/her lunch, is your child permitted to have food from the cafeteria?
Yes _______ or No _________

2.) What prescription medication, if any, does your child take at home? ____________________________

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3.) Will your child need to have prescription medication at school? Yes or No (circle one)
Please specify ____

PRESCRIPTION MEDICATIONS CAN NOT BE GIVEN UNLESS WRITTEN ORDERS FROM YOUR CHILD'S HEALTH CARE PROVIDER ARE UPDATED EACH SCHOOL YEAR AND ON FILE IN THE SCHOOL HEALTH OFFICE. BLANK MEDICATION FORMS CAN BE PICKED UP AT THE SCHOOL HEALTH OFFICE.

4.) ***Please circle all health issues listed below that apply to your child:***

Hearing problem/hearing aid	Concussions (How many?)_____	GERD/reflux
Vision problem/glasses/contacts	ADHD/ADD	Diabetes
Asthma	Sickle Cell Trait	Scoliosis
Cancer	Cerebral Palsy	Kidney problems
Depression	Autism/Asperger's	Heart problems
Anxiety	Lyme Disease	High blood pressure
Nutritional/weight issues	Migraines	Seizures
PDD/NOS	OCD	PTSD

Please explain any items that you may have circled: ______________________________

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5.) Is there anything else you would like to bring to the attention of the school nurse? Please use reverse side if necessary:

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I have reviewed the school doctor's standing orders on the back of this form and the attached emergency medication protocol. I give permission for my child to receive care and medication as deemed necessary by the school nurse within the guidelines of the "Standing Orders" and "Emergency Medication Protocol". *I understand that it is my responsibility* to inform the school nurse in writing with specificity if I do not wish my child to receive care and medication in accordance with those guidelines.

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel and school transportation services when needed to meet my child's health and safety needs. I give permission to the school nurse to exchange information with my child's primary care physician and any other medical specialist who writes physician orders for my child for the purpose of referral, diagnosis and treatment.

Signature of Parent/Guardian __________________________________ **Date**________________

Parent/Guardian day time phone #: ____

Emergency Contact Name: ________________________________ **Phone:** ____________________

WE WILL SEND YOUR CHILD TO THE NEAREST HOSPITAL IN AN EMERGENCY.

Students <u>cannot</u> participate in athletics, after school activities, or school field trips when this form is not on file in the School Health Office.