Milltown School District
Milltown, N.J. 08850
Health Office
Annual Health History
Confidential

Student's Name **Date of Birth** **Grade**

Student Health Status

Complete the following checklist by indicating any of the following conditions, past or present. Include a separate sheet if additional detail is necessary.

	YES	NO		YES	NO
Heart Problem / defect			Hearing Deficit (Explain correction)		
ADD / ADHD			Hepatitis		
Anemia (Includes sickle cell)			Surgery (Identify type & year)		
Arthritis			Activity Restrictions		
Back / Neck Injury or Condition			Physical Disability		
Blood / Clotting Disorder			Mononucleosis		
Cancer / Leukemia			Epilepsy / Seizure Disorder		
Diet Restrictions			Vision Deficit (Explain below) Glasses?		
Head Injury / Concussion			Chickenpox		
Headaches			Other: (Explain below)		

Please give details for all that are marked **YES** above _____

Does your child have asthma? □ **YES** □ NO **If yes, Asthma Action Plan from Dr. is required.**

Does your child have allergies? □ **YES** □ NO Nature of allergy _____
Epipen prescribed? □ **YES** □ NO **If yes, Emergency Care Plan from Dr. is required**

Does your child have diabetes? □ **YES** □ NO **If yes, Diabetic Care Plan from Dr. is required.**

Does your child have seizures? □ **YES** □ NO **If yes,emergency health care plan from Dr. is required.**

Current Medications

Does the student take any medication (prescribed and / or OTC) ? □ Yes □ No
Explain:_____

Is medication required during school hours? □ **Yes** □ No
If yes, please obtain necessary permission form from the nurse. This form includes information required from the prescribing physician as well as parent/ guardian request authorization.

*** PLEASE COMPLETE REVERSE SIDE ***

Annual Health History
(Continued)

Student Name

Consents and Signature

CONSENT TO CONTACT DOCTOR: The school nurse has my permission to contact my child's doctor if medically necessary. □ YES □ NO

CONSENT FOR SCREENINGS BY THE SCHOOL NURSE: I consent to screenings for scoliosis, hearing, vision, etc. by appropriately trained personnel. □ YES □ NO

CONSENT FOR SPORTS OR SCHOOL PHYSICAL BY SCHOOL PHYSICIAN: (with notification in advance) □ YES □ NO

I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact their learning.
I understand that medications of any kind are not allowed on school grounds without the proper medication authorization form on file. I understand that the school nurse MAY NOT administer any medications without the proper medication authorization form on file from my child's doctor. I understand that I (not the child) must bring medications to school in the original container, labeled with my child's name. Medications not picked up by the parent / guardian by the last day of the school year will be discarded.
I understand that for the safety of the child, or to provide for their educational program, the school nurse may need to share information about my child's condition with appropriate school staff. This will be done in a confidential manner. If I do not wish that information shared, I must request this in writing and file it with the school nurse.

Parent / Guardian Signature

Date