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

Student's Name ________________________________ **Grade** _______ **Date of Birth**_______________

Family Physician __________________________________ Phone Number ____________________________

In case of emergency, which hospital do you prefer your child be brought? ____________________________

Family Dentist ____________________________________ Phone Number ____________________________

In the table below, indicate any of the following conditions, past or present.

CONDITION	YES	NO	CONDITION	YES	NO
Heart Problem / Defect			Hearing Deficit (Explain correction below)		
ADD / ADHD			Hepatitis		
Anemia (Includes Sickle Cell)			Surgery (Identify type & year below)		
Arthritis			Activity Restrictions		
Back/Neck Injury or Condition			Physical Disability		
Blood / Clotting Disorder			Mononucleosis		
Cancer / Leukemia			Epilepsy / Seizure Disorder		
Diet Restrictions			Vision Deficit		
Head Injury / Concussion			Wears eyeglasses		
Headaches			Chickenpox		

Please give details for all of the health conditions marked YES above and/or other health conditions not mentioned.

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Please answer yes or no to the following questions:

Does your child have asthma? ☐ **YES** ☐ NO If yes, **Asthma Action Plan** from a doctor is **required**.

Does your child have allergies? ☐ **YES** ☐ NO If yes, **Doctor's Certificate** stating allergy is **required**.

Is an epipen prescribed**?** ☐ **YES** ☐ NO If yes, **Emergency Care Plan** from a doctor is **required**.

Does your child have diabetes? ☐ **YES** ☐ NO If yes, **Diabetic Care Plan** from a doctor is **required**.

Does your child have seizures? ☐ **YES** ☐ NO If yes, **Emergency Care Plan** from a doctor is **required**.

Current Medications:

Does the student take any medication? (prescribed and/or over the counter) ☐ **YES** ☐ NO
If yes, explain. ____
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Is medication required during the school day? ☐ **YES** ☐ NO
If yes, please obtain a permission form from Mrs. Conger. This form includes information required from the prescribing physician as well as parent/guardian request authorization.

Immunizations:

Has the student received new immunizations? ☐ **YES** ☐ NO
If yes, explain & enclose doctor's report. ______________________________
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Consents and Signature:

Consent to contact doctor ☐ **YES** ☐ NO
The school nurse has my permission to contact my child's doctor if medically necessary.

Consent for screenings by the school nurse ☐ **YES** ☐ NO
I consent to screenings for scoliosis, hearing, vision, etc. by appropriately trained personnel.

Consent for sports or school physical by school physician ☐ **YES** ☐ NO
Notification will be given in advance.

- 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.

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Parent/Guardian Signature Date