

# Frelinghuysen Township School

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## ANNUAL STUDENT HEALTH INFORMATION School Year 2025-26

**Name of Student:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Pediatrician:** \_\_\_\_\_ **Date of Last Physical:** \_\_\_\_\_

**Dentist:** \_\_\_\_\_ **Date of Last Dental Visit:** \_\_\_\_\_

### **Daily Medications:**

YES / NO Medications needed at home (list): \_\_\_\_\_

YES / NO Medication needed school (list): \_\_\_\_\_

(Note: Children are not permitted to bring medications to school, they must be brought in by a parent/guardian.)

### **Allergies:**

YES / NO Allergies (list) \_\_\_\_\_

Type of reaction/treatment: \_\_\_\_\_

### **Asthma**

YES / NO Regularly takes medication (list): \_\_\_\_\_

YES / NO Takes medication only when needed (list): \_\_\_\_\_

### **Diabetes**

YES / NO Year diagnosed: \_\_\_\_\_

### **Seizure Disorder**

YES / NO Type of seizure and date of last seizure: \_\_\_\_\_

YES / NO Requires emergency medication: \_\_\_\_\_

### **Other Health Concerns**

YES / NO Heart Condition: \_\_\_\_\_

YES / NO Behavior/Emotional Concerns: \_\_\_\_\_

YES / NO Other health concerns/chronic or recurring illness: \_\_\_\_\_

YES / NO Glasses or contacts needed. If YES, please indicate when your child is required to wear them \_\_\_\_\_

YES/NO Any restrictions/need for clearance (please send doctor note if necessary): \_\_\_\_\_

**All health information is considered confidential. In order to ensure the health and safety of your child, the above information may be shared with staff and health care providers as needed during the time your child is enrolled in Frelinghuysen Township Elementary School.**

YES / NO I give permission for the school nurse to share information with my child's teachers

YES / NO I give permission for the school nurse to contact my child's health care provider

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_