HEALTH INFORMATION

PLEASE PRINT ALL INFORMATION

Student Name (Last Name, First Name)_____ Grade_____

What was the date (month/day/year required) of your child's last physical? _____
Month/Day/Year

Is your child covered by health insurance? Yes_____ No_____

If yes, what is the name of your insurance company:_____

Does your child receive treatment for: Diabetes_____ Heart Condition_____ Asthma_____ Is an inhaler prescribed?_____

Seizure Disorder_____ Other_____

Please indicate if your child has any allergies to: Peanuts_____, Milk_____, Eggs_____, List Other Foods_____

_____, Latex_____, Bee Stings_____, Other Allergies (please give details)_____

_____

Has your physician prescribed an EpiPen for treatment of this allergy? Yes_____ No_____

Has he/she ever received Adrenaline for treatment of an allergy? Yes_____ No_____

If yes, when?_____
Month/Day/Year

Is your child receiving treatment for any medical condition(s) not listed? Yes_____ No_____

If yes, please give details_____

_____

Has your child had any contagious diseases? If so, please specify and include an approximate date:

_____ Date_____ _____ Date_____

Is your child currently taking any prescribed medication? Yes_____ No_____

If yes, please specify what medication, the dose, and when and how often it is administered_____

_____

Has your child been tested for Lead? Yes_____ No_____

If yes, please indicate date (month/day/year required) and the level of lead_____
Month/Day/Year Lead Level

Does your child use: Glasses/Contacts_____ Hearing Aid(s) _____ Any Other Physical Aids_____ If checked,

Please indicate what type of physical aid(s)_____

_____

List surgeries, illnesses, injuries (fractures, head injury, etc.) or previous hospitalizations:_____

_____

Please contact the school nurse if your child will be needing medications, treatments, or has special needs so that the school can properly prepare the Health Office to meet those needs

EMERGENCY CARE FOR INJURIES AND/OR SUDDEN ILLNESSES

In the event that a child requires emergency care for injuries, sudden illnesses or needs to be sent home because of illness, the parent/guardian is contacted immediately. Please list below the names, addresses and telephone numbers of 2 neighbors or relatives we can contact in case the parents/guardian cannot be reached at home, work or by cell:

Name	Home Phone # (include area code)	Cell Phone # (include area code)	Relationship to Student
Name	Home Phone # (include area code)	Cell Phone # (include area code)	Relationship to Student

Family Physician's Name	Address (city, state, zip)	Phone # (include area code)

Name of hospital the child can be taken to for emergency treatment when we are unable to contact you:

Hospital	Address (city only)	Phone # (include area code)

PLEASE SIGN BELOW TO INDICATE THAT WE HAVE YOUR PERMISSION TO CALL THE PHYSICIAN LISTED OR TO TAKE YOUR CHILD TO THE DESIGNATED HOSPITAL. YOUR SIGNATURE ALSO VERIFIES THAT ALL THE HEALTH INFORMATION GIVEN IS ACCURATE AND CORRECT.

Parent/Guardian Name (please print)	Parent/Guardian Signature	Date

FRELINGHUYSEN TOWNSHIP SCHOOL
IMMUNIZATION/HEALTH DATA SHEET

To the parents of _____ Birth Date_____

This form MUST be completed by your physician, signed and returned before September, in order for your child to attend school.

VACCINE TYPE	PRIMARY SERIES DOSES			BOOSTERS	
	1st	2nd	3rd	1st	10 year
Diptheria, Tetanus (DPT, TD)					
Oral Polio Trivalent (Sabin)			**3rd in series for monovalent**	**Booster must be at least 6 months after last dose in series.**	
Measles (live virus vaccine)			**Must**	**be given after**	**First birthday**
Rubella					
Mumps					
Chicken Pox					
Hepatitis B.					
Haemophilus B (HIB)					

T.B. Skin Test – MANTOUX ONLY Date_____ Result_____

History of Communicable Disease: (indicate date or age)

CH.POX_____ GERMAN (RUBELLA) MEASLES_____
MUMPS_____ PERTUSUS_____ MEASLES (RUBEOLA) _____
SCARLET FEVER_____ OTHER_____
Name of Illness Date or Age

PHYSICAL EXAMINATION

EYES_____ POSTURE_____ GLANDS_____
EARS_____ HEART_____ FEET_____
NOSE LUNGS GENERAL APPEARANCE
THROAT_____ ABDOMEN_____ NUTRITION_____
TEETH_____ SCOLIOSIS_____ HEIGHT_____
WEIGHT_____

COMMENTS:

_____

Medical/Surgical History: (Specify Diag., Date, Treatment)

_____

_____

Daily and/or Emergency Medication: (Specify Drug, Dose, Frequency & Reason for Medication)

_____

_____ _____
Physician Signature Date

File: KImmunizationChart