Fairfield Township School
375 Gouldtown Woodruff Road
Bridgeton, NJ 08302

# STUDENT HEALTH INFORMATION

Student's Name: _____
Last Name First Name Middle Name

**Please complete the following information:**

Does child have Health Insurance? **Yes** _____ If Yes, name of insurance company_____

No _____ NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name and address to the NJ Family Care Program to contact me about health insurance.

Signature_____ Printed Name_____
Date_____

***Written consent required pursuant to 20 U.S.C.§ 1232g (b)(1) and 34 C.F.R. 99.30(b.)***

| Has your child ever: | YES | NO | If Yes, please explain and include date: |
|---|---|---|---|
| Had an ongoing medical condition | ☐ | ☐ | |
| Seen a medical specialist | ☐ | ☐ | |
| Had allergies: | ☐ | ☐ | ☐food ☐environmental ☐insect ☐medication ☐other |
| Been hospitalized | ☐ | ☐ | |
| Had an operation | ☐ | ☐ | |
| Had an injury requiring an Emergency Room visit | ☐ | ☐ | |
| Missed 5 days of school in a row due to illness/injury | ☐ | ☐ | |
| Had a bone/muscle injury | ☐ | ☐ | |
| Passed out, had a concussion or serious head injury | ☐ | ☐ | |
| Had a convulsion/seizure | ☐ | ☐ | |
| Had a vision problem or condition | ☐ | ☐ | ☐ glasses ☐ contacts |
| Had a hearing problem or condition | ☐ | ☐ | ☐ hearing aid ☐ cochlear implant |
| Worn dental bridge, braces or mouthpiece | ☐ | ☐ | |
| **Have any family members under the age of 50 ever:** | **YES** | **NO** | **If Yes, please specify:** |
| Had a heart attack | ☐ | ☐ | |
| Had other serious health problems | ☐ | ☐ | |

Any other pertinent information to the above yes answers:

_____
_____

Student Physician_____ Phone Number_____

Student Dentist_____ Phone Number_____

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ADHD ☐GI CONDITIONS (ulcer, reflux, IBS,Crohns) ☐Scoliosis
☐ Asthma/trouble breathing ☐Headaches/Migraines ☐ Single organ
☐Autism/Asperger ☐Heart Conditions ☐Skin Condition
☐Dental Injuries ☐High Blood Pressure ☐Speech Condition
☐Diabetes ☐Ear Infections ☐Mental Health Condition ☐Urinary Condition
(depression, eating disorder, anxiety, OCD, ODD, etc)

| CURRENT MEDICATIONS | YES | NO | Please list name, dose, time(s) |
|---|---|---|---|
| Given at school | ☐ | ☐ | |
| Taken at home | ☐ | ☐ | |
| **ASSISTIVE EQUIPMENT** | **YES** | **NO** | **Please check all that apply** |
| During or outside of school | ☐ | ☐ | ☐crutches ☐walker ☐wheelchair ☐other: |
| **TREATMENTS** | **YES** | **NO** | |
| During or outside of school | ☐ | ☐ | ☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet _____ ☐ other _____ |

Please list any additional concerns: (use back of sheet if necessary)_____

_____

**I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this form and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.**

**In the event that physicians, other persons named on this form cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.**

**I will not hold the school district financially responsible for the emergency care and/or transportation of said child.**

**PARENT/GUARDIAN SIGNATURE_____DATE ____/____/____**

Teacher: _____ Grade: _____