Pemberton Township School District Student Medical History

Since the health of a child can affect his/her ability to learn in school, please assist our school personnel in providing the following information:

Student Name: _____ Birthdate: _____ M___ F___

Current Health Information - Please answer all the following questions by circling Yes (Y) or No (N). If Yes (Y) is circled, please provide additional information in the space provided.

Y	N	Is your child now under the care of a physician for a medical or surgical problem?
Y	N	Does your child have any physical limitations or restrictions?

Has your child experienced any of the following? Please make sure to circle if it is an allergy *or* a sensitivity.

Circle One			**If yes, give specific details, dates and medication**
Y	N	Asthma	
Y	N	ADD *or* ADHD **(circle one)**	
Y	N	Medication **allergy** *or* **sensitivity (circle one)**	
Y	N	Bee sting **allergy** *or* **sensitivity (circle one)**	
Y	N	Food **allergy** *or* **sensitivity (circle one)**	
Y	N	Seasonal or environmental allergies - **specify ➔**	
Y	N	Diabetes	
Y	N	Frequent ear infections	
Y	N	Frequent bladder or kidney infections	
Y	N	Frequent nosebleeds	
Y	N	Seizure disorder	
Y	N	Headaches	
Y	N	High blood pressure	
Y	N	Heart conditions	
Y	N	Concussion/head injury requiring medical treatment	
Y	N	History of fainting with exercise	
Y	N	Operations (not stitches for lacerations)	
Y	N	Fractures (broken bones) or dislocations	
Y	N	Speech problems	
Y	N	Mental health concerns	
Y	N	Hearing concerns-hearing aid/implant/ear tubes	
Y	N	Vision concerns-wears glasses and/or contacts	
Y	N	Any chronic/serious illness not mentioned above	
Y	N	***Medication taken at home or in school**	

If medication is needed in school it MUST be brought to the health office in the original container with a physician's order. The child's parent/guardian is required to complete the Student Medication Permission Form. Medication orders must be renewed EVERY school year or participation in ANY activities (after school, field trips, etc.) will be denied.

Y	N	****Tylenol/acetaminophen or Motrin/Ibuprofen given by the nurse every 4-6 hours**

**Our school physician has written orders for the nurse to give the recommended OTC manufacturer's dosage of Tylenol/ acetaminophen or Motrin/ibuprofen every 4-6 hours as needed for pain/fever with your permission as per nurse's assessment. By signing this form you hereby release the Pemberton Township BOE and all school district personnel from liability.

I understand that relevant information regarding my child's health may be shared with the appropriate school personnel and other healthcare providers as necessary. In case of serious illness or injury, I request that the school contact me or the physician named. If neither is available, I give the school permission to make all necessary arrangements to obtain emergency care for my child including taking my child to the hospital. I will also call the school when my child is absent.

Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____

Doctor's Name: _____ Dr.'s Phone: _____

Dentist's Name: _____ Dentist's Phone: _____