CLOSTER PUBLIC SCHOOLS
CLOSTER, NEW JERSEY 07624
HEALTH INFORMATION

Part 1: PARENT OR LEGAL GUARDIAN TO COMPLETE

Student's Name: (Last) (First) (M.I.) (Grade)

Student's Date of Birth: Sex: ( ) M ( ) F State or Country of Birth:

Student's Address: City: State: Zip:

Mother's Name/Legal Guardian: Home Phone: Cell Phone: Wk Phone:

Father's Name/Legal Guardian: Home Phone: Cell Phone: Wk Phone:

Students' Medical Provider: Address: Phone:

Additional Medical Specialists: Address: Phone:

Does your child have health insurance?( )No* ( )Yes- Name of Ins. Co:_____

- ***NJ family Care provides free or low cost health insurance for uninsured children and certain low income parents. Please contact 1-800-701-0710 or visit www.njfamilycare.org. We may release your name to the NJ Family Care Program to contact you regarding health insurance.***

My child has a medical, emotional, or behavioral condition that may affect his/her school day:

( ) No ( ) Yes-please describe:

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD

( ) **ALLERGIES**- If box is checked please list type and reaction:

Allergy Type:

( ) Food [list food(s)] _____
Reaction:_____
( ) Insect Sting [list insect(s)_____
Reaction:_____
( ) Medication [list medication(s)_____
Reaction:_____
( ) Other [list other]_____
Reaction:_____

Medications Prescribed for Allergy:

( )Oral antihistamine [Benadryl, etc.] ( )Epi-pen ( ) Epi-pen Jr. ( )Other:_____

( ) ASTHMA

( ) Environmental: (I.E., Tobacco, Dust, Pets, Pollen, E.T.C.)_____
( ) Weather:(I.E. Heat, Cold, Humidity)_____
( ) Exercise:( ) Yes (No_____
( ) Other:(I.E. Sprays or Smells)_____

Medications Prescribed_____
_____

( )**SEIZURE DISORDER**
Type: ( )Absence ( )Complex Partial( )Generalized/Tonic Clonic( )Other:_____
Physical Education Restrictions Per MD: ( ) NO ( ) YES:_____
Date of Last Seizure:_____Hospitalized: ( )NO( )YES_____
Medications Prescribed for SeizureDisorder:_____
_____

( )OTHER HEALTH OR EMOTIONAL CONDITIONS: PLEASE CHECK ALL THAT APPLY:

( ) ANEMIA ( ) ANXIETY ( ) ADD/ADHD( ) BEHAVIORAL ( ) CANCER ( ) AUTISM

( ) CEREBRAL PALSY ( ) CYSTIC FIBROSIS ( ) CHICKEN POX ( ) DEPRESSION

( ) DIGESTIVE DISORDERS ( ) HEART ( ) HEMOPHILIA ( ) SICKLE CELL ( ) SPEECH

( ) SKIN DISORDERS ( ) JUVENILE RHEUMATOID ARTHRITIS ( ) MIGRAINES ( ) OTHER-

EXPLAIN_____
_____

Medications Prescribed:_____
_____

Has your child ever been hospitalized, if so for what?_____
_____
Has your child had any fractures, if so please list?_____
_____

( ) **Special Procedures Required: [I.E. Catheterization, Oxygen, Gastrostomy Care. Tracheostomy Care, ETC**.] ( )NO ( ) YES-Explain_____
_____
_____

( ) **VISION CONDITIONS**: ( )**HEARING CONDITIONS:**
( ) Contacts/Glasses ( ) Hearing Devices
( ) Other _____ ( ) Other_____
_____
Does your child have an IEP or 504 Plan? ( )NO ( ) YES-Explain_____
_____
_____
Is there any other information you wish to share with us?_____
_____
_____

_____ _____
Parent/Legal Guardian Signature **Date**

The school nurse may share all health information with the faculty unless instructed otherwise.