Stone Harbor and Avalon Elementary School

2017-2018 Student Health History Update

Student Name: ____Date of Birth _______________Date: ______________Grade: ________

CURRENT HEALTH CONCERNS: PLEASE INITIAL AND GIVE PERTINENT DETAILS FOR THE FOLLOWING HEALTH CONCERNS THAT MAY IMPACT YOUR STUDENT'S EDUCATIONAL DAY. THIS INFORMATION MAY BE SHARED WITH STAFF AS APPROPRIATE.

_______ **THE STUDENT DOES NOT HAVE ANY MEDICAL CONCERNS OR RESTRICTIONS.**

______ ADD/ADHD

______ ALLERGIES (CHOOSE ALL THAT APPLY/DESCRIBE REACTION)

____FOODS: ____

____BEE STING/INSECT BITE: _______________________________

____MEDICATIONS: ____

____ PESTICIDES/CHEMICALS: _______________________________

____ OTHER: ____

_______ VISION PROBLEMS/ GLASSES: _______ CONTACTS: ________

______ BLOOD DISORDER/CANCER: ______________________________

______ DIABETES: ____

______ HEARING PROBLEM: ______________ HEARING AID(S) ______

______ HEART PROBLEMS: ____

______ MENTAL HEALTH CONCERNS: _____________________________

______ PHYSICAL DISABILITY/BLADDER/BOWEL: ________________

______ SEIZURES: ____

______ CONCUSSIONS: ____

______ ASTHMA: HAS THE STUDENT EXPERIENCED AN ASTHMA EPISODE IN THE PAST 12 MONTHS? ______ YES ______ NO. PLEASE SUBMIT AN **ASTHMA TREATMENT PLAN** TO THE HEALTH OFFICE YEARLY IF ASTHMATIC.

______ RECENT HOSPITALIZATIONS/OPERATIONS/MAJOR INJURIES OR ILLNESSES SINCE LAST HISTORY SUBMITTED: ____________________________

______ *****THE ABOVE MEDICAL CONCERN IS A CHANGE IN HEALTH CONDITION FROM THE LAST SCHOOL YEAR.**

MEDICATIONS (LIST ALL MEDICATIONS AND DOSAGES YOUR CHILD RECEIVES ON A ROUTINE BASIS (including medication taken at home)).

Medications taken daily or treatments given: ____

______ **MEDICATIONS ARE NOT REQUIRED AT SCHOOL**

IF THE STUDENT REQUIRES OVER-THE-COUNTER OR PRESCRIPTION MEDICATIONS OR TREATMENTS AT SCHOOL, THE HEALTH CARE PROVIDER AND PARENT MUST COMPLETE AND SUBMIT THE APPROPRIATE AUTHORIZATION FORM(S). OBTAIN FORMS FROM THE HEALTH OFFICE. Tylenol/Advil/Tums may be given with parental permission/request and signature -these have been approved by the school physician.

***N.J.S.A. 18A:40-12.5 ,P.L.2015, c.13 Permits the school nurse or trained delegate to administer epinephrine via a pre-filled auto-injector mechanism to any student without a known history of anaphylaxis, when acting in good faith believes the student is having an anaphylactic reaction.

IMMUNIZATIONS: PLEASE SUBMIT REPORTS OF ANY NEW/UPDATED IMMUNIZATIONS TO THE HEALTH OFFICE.

SOCIAL/FAMILY CHANGES SINCE LAST HEALTH HISTORY (EXAMPLES: DEATH, DIVORCE, MOVES, ETC.): _________________________________

REMINDER IT IS RECOMMENDED TO OBTAIN REGULAR PHYSICAL EXAMINATIONS BY YOUR HEALTHCARE PROVIDER AT LEAST ONCE DURING EACH OF THE CHILD'S DEVELOPMENTAL STAGES: EARLY CHILDHOOD (PRESCHOOL-GRADE 3); PRE-ADOLESCENCE (GRADES 4-6); AND ADOLESCENCE (GR. 7-12). PLEASE PROVIDE THE HEALTH OFFICE WITH REPORTS AS OBTAINED.

*******PLEASE SEE BACK OF THIS FORM TO SIGN AND DATE, THANK YOU.**

THE STATE OF NJ MANDATES ALL CHILDREN TO BE SCREENED YEARLY FOR: HEARING, VISION, HEIGHT, WEIGHT, BLOOD PRESSURE, AND SCOLIOSIS (STARTING AT AGE 10). THESE SCREENINGS ARE COMPLETED CONFIDENTIALLY IN THE HEALTH OFFICE THROUGHOUT THE COURSE OF THE SCHOOL YEAR. THE HEALTH OFFICE WILL NOTIFY OF ANY CONCERNS OR PROBLEMS.

ABSENTEEISM CAN BE REPORTED TO THE FRONT OFFICE OR THE HEALTH OFFICE VIA PHONE OR EMAIL: BOSSUYT@AVESNJ.ORG. PLEASE PROVIDE A MEDICAL NOTE FOR ANY ABSENCE OF OVER THREE CONSECUTIVE DAYS.

TEACHERS AND STAFF MEMBERS WILL BE GIVEN THIS HEALTH INFORMATION ON AN AS NEEDED BASIS. THIS IS TO ENSURE YOUR CHILD'S SAFETY DURING THE SCHOOL DAY. IF YOU DO NOT WISH THIS INFORMATION TO BE SHARED WITH STAFF PLEASE PROVIDE WRITTEN NOTIFICATION.

SIGNATURE OF PARENT/GUARDIAN: ____DATE: ______________________

***Email communication or notes home for office visits is routine unless there is an emergency then a phone call home will be made. (Minor incidents for bandages or bumps/bruises do not necessitate a note.)**