Audubon Public Schools
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HEALTH HISTORY

Student Name ____ **Grade** ______________

Date of Birth ________________ **Age**_______ **Sex: Male Female**

Does your child have any of the following:

	No	Yes	Explain
Allergy: • Bee Sting • Food • Medication Epi Pen Ordered by Doctor			bee sting reaction: ______________________________ food & reaction: ______________________________ medication & reaction:______________________________ Click here for the Epi Pen Packet
Allergies: Hayfever/Seasonal			season & symptoms:
ADD/ADHD			
Anemia			
Asthma			mild___ severe___ Click here for the Asthma Treatment Plan, required by N.J. Law
Behavioral Issues			
Broken Bone History			
Chronic Constipation			
Developmental Delay			
Dental Problems			
Diabetes			
Eczema			
Fainting Spells			
Frequent Ear Infections • Earaches • Hearing Loss • Tubes in Ears			
Headaches			
Muscle Problems			
Nosebleeds			
Physical Handicap			
Premature or Low Birth Weight			
Seizures/Epilepsy/Tics			
Speech Difficulty or Delay			
Stomachaches			
Vision problem • Color Deficiency • Corrective Lenses • Patch			type of corrective lens:______________________________ right_____ left_____

Has your child had any of the following:

Illness	No	Yes	Date(s) of Illness
Chickenpox			
Measles			
Mumps			
German Measles			
Lyme Disease			
Strep. Infection			
Scarlet Fever			
Rheumatic Fever			
Pneumonia			
Hepatitis (type)			
Mononucleosis			

Student Name ____ **Grade** ________________

Is your child currently receiving daily medication? **NO____ YES____**

- If YES, please give name of medication, amount and reason: ____
- Will your child require the medication during school hours? **NO____ YES____**

Click here for the Medication Consent Form, which must be completed by parent and doctor for any medication, including over the counter medication, which needs to be given during school hours.

Was a health problem and/or handicap present at birth? **NO____ YES____**

- At what age was diagnosis made?
  Diagnosis:____

List any operations, injuries or hospitalizations and dates:

Operations/Injuries/Hospitalizations	*Date*
____	___________________
____	___________________
____	___________________

- Do any of the conditions still affect your child? **NO____ YES____**
- If YES, please list____
- Physical Ed Activity: Does condition restrict his/her activities? **NO____ YES____**

Do you have any concerns about your child's health? If so, please describe_______________________________
____

I give permission for health concerns to be shared with appropriate staff having contact with my child **YES____ NO____**

I give permission for my child to receive school health services and screenings (vision, hearing, height, weight, and scoliosis) according to New Jersey School Health Services Guidelines **YES____ NO____**

Authorization for Medical Treatment

*I/We, the undersigned, do hereby authorize officials of the Audubon School District to contact directly the persons named on the "**EMERGENCY CONTACT INFORMATION**" and do authorize the appropriate school personnel to render first aid as may be deemed necessary in an emergency, for the health of the said child. Pertinent medical information may be shared with school personnel as needed.*

*In the event that parents or other persons named on the "**EMERGENCY CONTACT INFORMATION**" cannot be contacted, the school officials are hereby authorized to take whatever action necessary in their judgment, for the health of aforesaid child, including transportation to the nearest medical emergency facility.*

I will not hold the Audubon School District financially responsible for the emergency care and/or transportation for said child.

Name of Child's Doctor:_________________________________ **Telephone #**________________________
Date of Last Medical Exam:______________ **Date of Last Polio Immunization:**__________ **Date of Last Lead Test:**__________

Health Insurance Informtion: Does child have health insurance?
YES_______ **Name of Insurance:**____
NO_______ **Do you want Medicaid or NJ Family Care to contact you about free or low-cost health insurance? YES____ NO____**

EMERGENCY CONTACT INFO (PERSONS who will assume temporary care of your child if you cannot be reached)

	Emergency Contact #1	**Emergency Contact #2**	**Emergency Contact #3**
Full Name			
Relationship to Student			
Home Telephone #			
Cell Phone #			
Work Telephone #			

Parent/Guardian Printed Name______________________________**Signature** __________________________________Date_____
Parent/Guardian Printed Name______________________________**Signature** __________________________________Date_____