

**Audubon Public Schools**  
 350 Edgewood Avenue, Audubon, New Jersey 08106-1545  
 Phone (856) 547-7695 • Fax (856) 546-8550  
[www.audubonschools.org](http://www.audubonschools.org)  
**HEALTH HISTORY**

Student Name \_\_\_\_\_

Grade \_\_\_\_\_

Date of Birth \_\_\_\_\_

Age \_\_\_\_\_

Sex: Male Female

Does your child have any of the following:

	No	Yes	Explain
Allergy: <ul style="list-style-type: none"> <li>• Bee Sting</li> <li>• Food</li> <li>• Medication</li> </ul> Epi Pen Ordered by Doctor			bee sting reaction: _____ food & reaction: _____ medication & reaction: _____ Epi Pen Packet at: <a href="http://audubonschools.org/assets/Uploads/Marshall/Shared-documents/Nurse/EpiPacketNov2016.pdf">http://audubonschools.org/assets/Uploads/Marshall/Shared-documents/Nurse/EpiPacketNov2016.pdf</a>
Allergies: Hayfever/Seasonal			season & symptoms: _____
ADD/ADHD			
Anemia			
Asthma			mild___ severe___ NJ Law requires Asthma Treatment Plan found at: <a href="http://www.pacnj.org/pdfs/atpstudent2012.pdf">http://www.pacnj.org/pdfs/atpstudent2012.pdf</a>
Behavioral Issues			
Broken Bone History			
Chronic Constipation			
Developmental Delay			
Dental Problems			
Diabetes			
Eczema			
Fainting Spells			
Frequent Ear Infections <ul style="list-style-type: none"> <li>• Earaches</li> <li>• Hearing Loss</li> <li>• Tubes in Ears</li> </ul>			
Headaches			
Muscle Problems			
Nosebleeds			
Physical Handicap			
Premature or Low Birth Weight			
Seizures/Epilepsy/Tics			
Speech Difficulty or Delay			
Stomachaches			
Vision problem <ul style="list-style-type: none"> <li>• Color Deficiency</li> <li>• Corrective Lenses</li> <li>• Patch</li> </ul>			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 \_\_\_\_\_ Date of Birth \_\_\_\_\_

**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 \_\_\_

If any medication needs to be given during school hours a consent form, <http://audubonschools.org/assets/Uploads/Marshall/Shared-documents/Nurse/PrescriptionNonPrescriptionMedicationConsentFormNov2016.pdf>, will need to be completed by the parent and doctor ordering the medication (including over the counter medication).

**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 Information:** 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? NO \_\_\_ YES \_\_\_

**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 \_\_\_\_\_