WASHINGTON TOWNSHIP SCHOOL DISTRICT: Annual Health Information Form
PORT COLDEN SCHOOL BRASS CASTLE SCHOOL

Pupil's Last Name: _____ **First Name:** _____
Birth Date: _____ **Grade/Teacher:** _____

PLEASE COMPLETE ALL APPLICABLE AREAS AND SIGN:

1. Please note special **health conditions**, i.e. chronic disease, recent surgeries or significant injuries (such as broken bones, stitches), wears glasses, concussions, delayed clotting time, etc.

   _____

   This information may be shared with school personnel on a "need to know basis." If you do not want this information shared, please notify the School Nurse in writing.
2. **Allergies** (include food/medications/environmental; reaction & treatment):

   _____

   This information may be shared with school personnel on a "need to know basis." If you do not want this information shared, please notify the School Nurse in writing.
3. **Regular/routine medications** my child is presently taking: _____
4. My child has **asthma**: ☐ **NO** ☐ **YES** Asthma medication: _____
5. **Scoliosis Screening** *5th grades students only*: The School Nurse has permission to screen my child for scoliosis.
   Circle one and sign: ☐ **YES, examine my child X** _____ **(signature)**
   ☐ **NO, I will have the exam done my child's health care provider x** _____ **(signature)**
6. In the case of an unknown allergic reaction, the School Nurse or a trained volunteer delegate has standing orders from our school physician to administer **Epinephrine,** via an auto-injector, or **Diphenhydramine** (ex: Benadryl) depending on the degree of allergic reaction. 9-1-1 and the parent are always called if an Epinephrine auto-injector is used. Dose for either medication is determined by the weight of the child**.**
7. The School Nurse has standing orders from our school physician to administer/apply hydrocortisone ointment, bacitracin antibiotic ointment, first aid cream, calamine or caladryl, skin lotion, cough drops, petroleum jelly, sting kill/insect relief sting pads for bee stings, eye wash and anbesol/orajel. Parents will not be called for these unless there is a medical indication to do so. **Please notify the nurse in writing if your child may not have any of these listed.**
8. Does your child have Health Insurance?
   ☐ **YES** Name of insurance carrier: _____
   ☐ **NO** ☐ please check and sign if you would like us to release your name and address to the NJ FamilyCare program so they can contact you about health insurance for your child. NJ FamilyCare provides free or low-cost health insurance for uninsured and certain low-income families. For more information call 800-701-0710 or visit www.njfamilycare.org to apply on-line. Written consent is required pursuant to 20 U.S.C. 1232g(b)(1) and 34 C.F.R. 99.30(b).
   X _____ (**signature**)
9. Name of Pediatrician or Family doctor: _____ Phone No. _____
10. Does your child have Dental Insurance? **Yes** ☐ **No** ☐

EMERGENCY CONTACTS: If the school cannot get in touch with the parent/guardian, please name two alternate contacts (relatives, neighbors) that live *nearby* who can be called upon if the child is too sick to remain in school.

NAME:	HOME PHONE #:	CELL PHONE #:

I do hereby release, discharge, and hold harmless the Washington Township School District, its agents and employees from any and all liability and claim whatsoever for the self-administration or administration by the nurse or trained delegate where applicable, of the medications listed above, as a result of any injury arising from stated medications.

In the event of a health emergency and a parent cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. Your signature below verifies the information on this form is accurate and up to date and allows the Washington Township School District to share this information with treating medical personnel in the event of an emergency**.** I will not hold the school district financially responsible for the emergency care and/or transportation for said child. If at any time the directives noted above must be changed, I will notify the school in writing.

_____ _____ _____
Parent/Guardian Signature Date School Year

Authorization for the Administration of Over the Counter (OTC) Medication in School for Acute Illnesses

The school nurse is authorized to administer the following medications in the health office. Parental/guardian permission is required before the student can receive any of the listed medication. Please complete the following if you grant permission.

Student Name: _____ Grade: _____

Allergies: _____

I authorize the administration of (check all that apply):

- ☐ Acetaminophen (Tylenol equivalent) dosed according to product label
- ☐ Ibuprofen (Advil, Motrin equivalent) dosed according to product label
- ☐ Antacid tablets (TUMS equivalent)
- ☐ Cough drops
- ☐ Allergy eye drops

I request that my child be assisted in taking the medication described above at school by the School Nurse/School Nurse Substitute pursuant to N.J.A.C.: 6A:16-2.3. I understand the ultimate responsibility for the administration of medication is mine and I am fully aware that the duties of the School Nurse may require her presence at another location at the time the medication is needed.

I do hereby release, discharge, and hold harmless the Washington Township School District, its agents and employees from any and all liability and claim whatsoever for the self-administration or administration by the nurse or trained delegate where applicable, of the medications listed above, as a result of any injury arising from stated medications.

Signature of parent/guardian: _____ Date: _____

Printed Name: _____ Phone (first # to call): _____

Weight (*as measured by school nurse)* _____*lbs.*