Audubon Public Schools
350 Edgewood Avenue, Audubon, New Jersey 08106-1545
Phone (856) 547-7695 • Fax (856) 546-8550
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	
Allergy: • Bee Sting • Food • Medication **Epinephrine Ordered by Doctor**			bee sting reaction: ____ food & reaction: ____ medication & reaction:____ Click here for HEALTHCARE PROVIDER'S ORDERS FOR ALLERGY EMERGENCY TREATMENT 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 ____ 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**____

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**____

Routine screenings are performed, in the Audubon Public schools, by certified school nurses as part of a comprehensive health program required by New Jersey law. Pupils can be exempted from screenings with a written request from the parent/guardian.

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: _________

Name of Child's Dentist:____**Telephone #**________________________
Date of Last Dental Exam: _________

Health Insurance Information: Does child have health insurance?

YES____ Name of Insurance:____
Name of Subscriber: ____
I.D. Number:____
Group Number:____

NO____ Do you want Medicaid/NJ Family Care to contact you about free or low-cost health insurance? No___Yes___

Parent/Guardian Printed Name____________________________**Signature** __________________________________Date_____

Parent/Guardian Printed Name____________________________**Signature** __________________________________Date_____