EGG HARBOR CITY PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

CHARLES L. SPRAGG ELEMENTARY SCHOOL
601 Buffalo Avenue, Egg Harbor City, NJ 08215
Phone (609) 965-1034 (Nurse's Office: ext 137)
Fax (609) 965-3561

EGG HARBOR CITY COMMUNITY SCHOOL
730 Havana Avenue, Egg Harbor City, NJ 08215
Phone (609) 965-1034 (Nurse's Office: ext 127)
Fax (609) 965-4742

MEDICAL HISTORY QUESTIONNAIRE
(To be completed and signed by parent/guardian)

Student's Name: _____ Date of Birth: _____ Grade: _____

YES	NO	Please check (✔) response.
		Has the student been advised by a physician not to participate in any sport? If yes, explain: _____
		Has the student ever experienced a loss of consciousness after an injury? If yes, explain: _____
		Has the student ever had a dislocation or fractured bone? If yes, what? _____ When? _____
		Has the student ever been hospitalized or undergone surgery? If yes, why? _____ When? _____
		Does the student take medication on a regular basis? If yes, name of medication: _____ For what condition? _____
		Does the student have any allergies to foods, medications or environmental agents? If yes, to what? _____ Describe the signs and symptoms and how they are treated. _____
		Does the student have a special meal accommodation due to a medical reason? If yes, please state the reason for the accommodation in detail: _____ _____ Please specifically list foods that the student should not consume and why: _____ _____ *Please note it is the parents'/guardians'/student's responsibility to specifically request the alternate entree on days when foods that should not be consumed are served.
		Does the student have asthma? If yes, explain: _____
		Does the student have a reaction to bee stings? If yes, describe the signs, symptoms and treatment. _____ _____
		Has the student ever experienced frequent chest pains or palpitations? If yes, explain: _____
		Has the student recently suffered fatigue or undue tiredness? If yes, explain: _____
		Does the student have a history of fainting with exercise? If yes, explain: _____

Student's Name: _____ Date of Birth: _____ Grade: _____

YES	NO	Please check (✔) response.
		Has any family member suffered Sudden Death? If yes, explain: _____
		Does your child have a medical healthcare provider(Pediatrician). If yes, please provide the name and phone number for the office: Name._____Phone #_____
		Does the student wear glasses? Date of last vision exam: _____
		Has the student been seen by a dentist? Date of last dental exam: _____ Does the student have an orthodontic appliance? ☐ Yes ☐ No
		Do you currently have health insurance? If yes, name of insurance company: _____ If no, **NJ Family Care** provides free or low cost health insurance for uninsured children and certain low income parents. Call **800-701-0710** or visit www.njfamilycare.org to apply online.
		Would you be interested in receiving information on New Jersey Family Care, a state sponsored insurance program for working people who are uninsured? Indicating YES will give us permission to release your name and address to NJ Family Care Program so they may contact you.
		Do you have dental insurance? If yes, name of insurance company: _____
		Do you have vision insurance? If yes, name of insurance company: _____
		Does your child have any other medical problems that the school should be aware of? If yes, explain: _____

HEALTH SCREENINGS: Your child will have a limited health screening, which will consist of measuring the height, weight, BMI, blood pressure, as well as basic vision and hearing tests. The school nurse will perform this during the current school year as per state and district requirements. A referral will be sent home if your child requires follow-up by their health-care provider.

SCOLIOSIS SCREENINGS: Students will also be screened for scoliosis during their health screening. A scoliosis screening is performed by observing the uncovered spine and taking a measurement using a Scoliometer. Boys and girls are screened separately and individually in a private screening area.

If you do not wish for your child to be screened in school, please submit this request in writing to the school nurse within seven (7) days of receipt of this notice. **This request will need to be renewed in writing on a yearly basis.** It will then become the responsibility of the parent/guardian, as desired, to have your child examined by his or her health care provider.

The information on this form may be shared with school personnel having contact with my child. In the event of an emergency, this information can also be given to ambulance/hospital personnel.

EMERGENCY CONTACT INFORMATION List contacts (other than parent/guardian) in case of an emergency. These individuals would be permitted to sign your child out of school if you are unavailable.		
Name	Relationship to Student	Phone

I certify all the information I have provided is true to the best of my knowledge. I give permission for the school nurse to share medical information with the appropriate school personnel who may have contact with my child. Further, I give my permission that in the event of an emergency my child may be taken to nearest hospital. I also authorize first aid and/or emergency medical treatment if necessary in the case of an emergency. I also will provide the school updated information if any information should change during the school year. **I authorize the release of any medical information from any healthcare provider for the purpose of maintaining accurate and up-to-date health information for my child. I give permission of the school nurse to administer Tylenol or Ibuprofen *(at weight appropriate dosage listed on box)* for fever, headache, pain, or menses.**

Parent/Guardian Signature: _____ Date: _____