Cape May County Technical High School

Annual Health Update for Returning Students Enrolled in Full Day High School: School year: 20__ to 20__

Student Name (print):_____ Grade:_____ D.O.B.___/___/___

Student's Physician:__ _____Telephone:_____ Dentist:_____Telephone: _____

Does child have Health Insurance?

YES ___ If Yes, name of insurance company:_____

NO ___ If No, NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online.

You may release my name and address to the NJFamily Care Program to contact me about health insurance.

Signature: _____ Printed Name:_____ Date:____/____/____

Written consent required pursuant to 20U.S.C. & 1232g (b) (1) and 34 C.F.R. 99.30(b)

Check health conditions your child has: Only pertinent health information is shared with staff on a "need to know basis" unless otherwise directed by you or your child. For information you want shared with the bus driver complete the attached form.

- ☐ Allergy to Medication(s): list _____
- ☐ Latex allergy (medical gloves, tapes, etc): If exposed, does your child require emergency epinephrine? NO YES *
- ☐ Food allergy - List foods allergic to:_____
  If exposed to food allergy, does your child require emergency epinephrine medication? NO YES *
- ☐ Insect allergy - List insects allergic to: _____
  If stung/bitten by insect, does your child require emergency epinephrine injection? NO YES *
  **** All emergency epinephrine orders and plans must be updated annually.***
- □ Diabetes: Type: 1 or 2 ***Provide the school nurse with annually updated "Diabetic Health Care Plan".***
- □ Seizure Disorder: Type of seizure: _____ Date of last seizure: _____
  Provide the school nurse with annually updated "Seizure Health Care Plan".
- □ Asthma: Carries inhaler in school and/or sports? NO YES If "yes," name of inhaler: _____
  **** All asthma inhaler orders and plans must be updated annually.***
- □ Bleeding disorder: name/type of disorder:_____
- □ ADHD/ADD Medication:_____ If administered at school, call nurse for medication forms.
- □ Migraine headaches evaluated by a physician. Medication:_____
- □ Vision: ☐ glasses ☐ contacts ☐ color deficiency ☐ Nystagmus ☐ Low vision, blindness, etc: Type:_____
- □ Hearing difficulty: which ear: ___Right ___Left ___Both Hearing aids worn? NO YES
- □ Mental/emotional health diagnosis:_____ Share information with teachers? YES NO
- □ Hospitalizations, surgeries, injuries or illnesses the **past 12 months**. Explain: _____
- □ Other problem(s) not listed above. Explain: _____
- □ Medication(s) taken (indicate name of medications, doses and times taken): _____

_____

In the event of a medical emergency, your child will be transported to the nearest hospital emergency room.

Parent/guardian Name:_____ Address: _____

Street Town/City Zipcode

Mailing address (if different from above):_____

Home Telephone: _____ Work Telephone:_____ Cell:_____

If we are unable to reach you, contact: Name: _____ Relationship:_____ **Tele: _____**

I give my permission for the school nurse to administer as indicated and outlined by the school physician: (cross off any items you do not want your child to receive): acetaminophen or ibuprofen, Cepacol/Halls lozenges, topical antibiotic ointments and antiseptics, calamine lotion, hydrocortisone crème, oragel/ambesol, blister care 2nd skin, solarcaine/foille/watergel for burns.

Parent/guardian signature:_____ Date:_____

Attachment: Communication of Student Health Needs to Transportation Coordinator for Full-Day High School Student 6/2014

Cape May Technical High School
188 Crest Haven Road
Cape May Court House, New Jersey 08210
School Nurse Office: 465-2161 ext. 658

Communication of Student Health Needs to Transportation Coordinator for Full Day High School Students

If your child does not have any medical condition(s) that the bus driver needs to be aware of you do not need to complete this form.

Dear Parent/Guardian,
As transportation staff may change, or be substituted, it may be important for your child's bus driver to know of your child's medical condition and emergency contact information. This form will serve to communicate any special health concerns or treatments to your child's bus coordinator. Return this form to the School Nurse in person or postal mail. Please do not return this form with your child as such papers may be lost in transit.

Sincerely,
Lynda Zipparo, School Nurse

********** Parent/Guardian completes the information below**********

Student's name (print):_____ D.O.B.____/____/_____ Grade:_____

□ Seizure Disorder List medications taken to control seizures, if any:_____
_____

□ Insulin Dependent Diabetic: Must have glucose source available (i.e. glucose gel, honey, cake icing)

□ Asthmatic needs to carry inhaler: Name of inhaler:_____ Dose:#___ inhalations taken

□ **Life Threatening Allergy**
My child needs to self-administer his/her prescribed auto-injector **epinephrine** (ie. EpiPen) if exposed to:
Allergic to: Food(s):_____ Insects/bees:_____ Other: _____

□ Bleeding Disorder: name/type of disorder:_____

□ Medication Allergies:_____ Is child allergic to latex? NO YES

□ Other medical condition(s) you want the bus driver to know: _____

In emergency contact: Parent/Guardian:_____
Telephone(s) Home:_____ Work:_____ Cell:_____
Street Address: _____ City/town:_____

If unable to reach parent or guardian, contact:
Name:_____ Telephone: Home:_____ Work:_____ Cell:_____

Your child's Primary Care Physician's name: _____ Telephone:_____

********** FOR OFFICE USE ONLY**********

□ Note for School Nurse: Original to Bus Transportation Coordinator, copy to student chart.

Name of Bus Transportation Company:_____ Bus number:_____ 6/2014