Cape May County Technical High School
188 Crest Haven Road
Cape May Court House, NJ 08210
School Nurse: (609) 465-2161 ext. 658 Fax: (609) 465-5033

Annual Health Update for Returning Students in Partial (Half) Day Career/Technical Programs 20__to 20___

Student Name (print):_____Grade:____ D.O.B.___/___/___ Name of home school:_____
Student's Physician:_____ Telephone:_____
Student's Dentist:_____ Telephone:_____
Health Insurance: YES NO If yes, name of insurance:_____
Date of your child's last tetanus (Td or Tdap) booster: ____/____/____

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.

- ☐ 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 *
  If "YES" you provide all school nurses with the annually updated medical order and emergency plan.
- □ Diabetes: Type: 1 or 2 **Provide all school nurses with the annually updated "Diabetic Health Care Plan".**
- □ Seizure Disorder: Type of seizure: _____ Date of last seizure: _____
  Provide all school nurses with the annually updated "Seizure Health Care Plan".
- □ Asthma: Carries inhaler in school and/or sports? NO YES If "yes," name of inhaler: _____
  If "YES" provide all school nurses with the annually updated "Asthma Action Plan".
- □ 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. Please complete the following information in the event your child is injured or ill.

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:_____ 6/2014