MOUNT HOLLY TOWNSHIP PUBLIC SCHOOLS-MOUNT HOLLY, NJ
HEALTH OFFICE INFORMATION FORM

Student's Name ________________________________ DOB: _______________ Grade: _____

Home Address: ____

Parent/Guardian's Name: ____

Student's Dentist: _________________________________ Dentist's Phone: __________________

Date of last Dental Exam: _________________________ Date of last Vision Exam: _____________________

Student's Physician: _________________________________ Physician's Phone: _______________

Date of last physical: _________________________________ Purpose: ___ Routine ___ Illness

If illness, please explain: ____

Is student currently under a physician's care? Yes No

In the past, has your child had any health problems in the following areas?

Asthma: ____

Allergies (Specify): ____ Epi-Pen: ___ YES ___NO

Hives/Bee sting reactions: ____ Epi-Pen: ___ YES ___NO

___Arthritis	___Headaches, frequent	___Skin Problems
___Asthma	___Hearing Aid/other device	___Sleep Problems
___Cancer	___Hearing Problem	___Sore Throat Frequent
___Concussion/Head Injury	___Heart Disease	___Speech Issues
___Constipation/Diarrhea	___Hemophilia	___Stomachaches, Frequent
___Cystic Fibrosis	___Hepatitis	___Surgery/Hospitalization
___Diabetes	___Kidney Disorders	___Tonsillectomy
___Ear Tubes Inserted	___Meningitis	___Vision Problem
___Eczema/Dermatitis	___Mononucleosis	___Glasses Contacts
___Epilepsy/Seizures	___Neurological Disorders	___Color Blindness
___Fainting	___Orthopedic Problems	
___Fractures	___Sickle Cell	

Please list details as needed if checking any of the above: ____

____

Please list any illnesses within the last 12 months: ____

SIGNATURE OF PARENT/GUARDIAN: ____ Date: __________

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

MOUNT HOLLY TOWNSHIP PUBLIC SCHOOLS
MEDICAL PERMISSION FOR HEALTH SERVICES

HEALTH OFFICE INFORMATION FORM (Page 2)

____ ____________________
Student's Last Name First Name

Does this child have any health insurance including NJ Family Care/Medicaid, Medicare, private or other?

___ **No:** My child does not have health insurance. You may release my name and address to the NJ Family Care Program to contact me about health insurance. 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.
___**Yes:** My child has health insurance (Please indicate insurance company below)

Name of child's health insurance company: ____________________________________

I understand that relevant information regarding my child's health may be shared with appropriate school personnel and other health care providers necessary.

In case of emergency, illness or accident the school is authorized to proceed as indicated on the District's Enrollment/Emergency Procedure Form

I hereby give permission for my child to receive the following medical attention as part of the school health program:

1. Height, weight, and blood pressure screening annually.
2. Vision/hearing screening every other year.
3. I understand that each student must have a physical examination upon entry into the Mount Holly Township School District. This examination must be done no more than 365 days prior to entry and must state what, if any, modifications are required for full participation in the school program. If a physical has not been done 365 days prior to entry to school, one must be done within 90 days of registration.
4. I understand the importance of obtaining subsequent examinations at least once during each of the student's development stages through my home physician:
   - Early childhood (pre-school through grade 3)
   - Pre-adolescence (grades 4 through 6)
   - Adolescence (grades 7 through 12)
5. I understand that scoliosis screening will be done by the school nurse on all students ages 10 to 18 bi-annually. Scoliosis is a lateral curve of the spine, most commonly found during the adolescent-growth period.
6. I have received information regarding the NJ Family Care Program for students who are knowingly without medical coverage.

If your child will need to take medication in school (i.e. Tylenol, Adderall, inhalers, etc.) please contact the nurse's office for the medication permission form. Students are not permitted to carry medication with them.

In most cases of extreme emergency the student will be taken to Virtua Hospital/Mount Holly via the emergency squad.

I understand that the relevant information regarding my child's health may be shared with appropriate school personnel and other health care providers as necessary.

SIGNATURE OF PARENT/GUARDIAN: ____ Date: __________