Colts Neck Township Schools
Health History

To be completed by Parent/Guardian:

Name of student: _____ Male ☐ Female ☐

Student's date of birth: _____ Entering Grade _____

Mother's first and last name: _____

Father's first and last name: _____

Address: _____ Home Phone #: _____

Pediatrician's name: _____ Phone #: _____

Medical History: _____

Allergies: _____

Medications: _____

**Please note that if medication is required during school hours, you must provide a physician's order and written parent/guardian permission. Forms are available on Health Office web page, or from your child's school nurse.

Vision or Hearing Problem(s): _____

Glasses/ contact lenses: _____ Dental Appliances: _____

Please check any health concerns that pertain below. Please explain checked items on an attached sheet or in the medical history section.

Chicken Pox		Fainting Spells		Hepatitis	
Bladder/ Kidney		Mononucleosis		Migraines	
Congenital Defects		Otitis Media		Heart Disease	
Rheumatic Fever		Neuromuscular Disorder		Arthritis	
Asthma		Strep Infections		Diabetes	
Convulsions/ Seizures		Lyme Disease		High Blood Pressure	
Drug Sensitivities					

Please provide detailed information regarding any of the following:

History of excessive bleeding? _____

Serious injuries or surgical procedures? _____

Speech/ language concerns? _____

Learning or behavioral concerns? _____

Restrictions that may affect the student's participation in school activities/ physical education?

_____ _____

Significant developmental delays? _____

Permission to: Remove tick if able: __yes __no. To give saltine crackers: __yes __no

I understand that medical information will be shared with people in the school who need to know. In case of emergency, if unable to contact parent/guardian, I give permission for authorized hospital personnel to provide necessary emergency care for my child.

Parent/ Guardian signature: _____ Date: _____

HEALTH INSURANCE INFORMATION: Do you have health insurance? Y or N

Name of Health Insurance Provider: _____

If you are uninsured and do not have medical insurance, would you like the district to release your information to NJ FamilyCare? Y or N

Please return this form when you register your child.

Revised 2/24/2015