High Bridge School District
High Bridge, NJ
Health Office Notification of New Student

Student's Name:_____Grade:_____Date of Birth:_____

Parent/Guardian:_____Entry Date:_____

Address:_____Telephone:_____

Last School Attended:_____Municipality:_____

County:_____State:_____Country (if outside U.S.):_____

Health History:

Known Allergies: NO __ YES__ If yes: Medications _____Seasonal_____ Latex____ Bee Stings_____
Allergies to Foods_____
Other Allergies (not listed above, i.e. perfume, dust, etc.)_____
What happens to your child when exposed to above:_____

Throughout the year Service Dogs will be in our schools. Does your child have issues/concerns with dogs?
NO_____ YES _____ If yes, explain:_____

Ear tubes? NO____ YES____ If Yes: Date Inserted: _____ Right _____ Left _____ Removed:_____
Vision Problems? NO____ YES___ If yes: Wears Eyeglasses _____ Contact Lenses____ Soft ____ Hard ____
Why?_____When to wear?_____
Significant illnesses (**COVID**, strep, chicken pox, etc.) and approximate date(s):
_____
Serious injury/**concussion**/surgery/hospitalization and approximate date(s):
_____

Any History of Developmental Delays:_____
Any current health problems:_____
_____

Other conditions/special circumstances (emotional/behavioral issues, etc.):_____
_____

Any physical limitations (A Doctor's note is required):_____

Medication taken regularly:

Medication	Dosage	Reason

Will this medication be needed during school hours? No _____Yes_____ If yes, a doctor's order should be submitted along with the medication directly to the School Nurse on the first day of school.

Emergency medications required: (A doctor's order must be submitted along with the medication directly to the School Nurse on the first day of school-forms are available on the website)
Inhaler _____ Epi Pen _____ Glucagon (for diabetics) _____ Other _____

Health Care Provider Information

Family Physician/Pediatrician:		Phone Number:
Address:		

___**My child has had a physical exam in the past year*.
___**I will take my child for a physical exam.*
***Please have your health care provider complete the physical exam form (found on the school's website), and return it to the Health Office ASAP.**

Date of last dental exam:_____Dentist Name:_____

Does your child have health insurance? No _____Yes_____
If **YES**, name of insurance company
_____

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 NJ FamilyCare Program to contact me about health insurance.

Permission for care: In the event of accident or illness, my child's school nurse has my permission to contact the physician(s) listed above regarding their care.
____ I give my permission
____ I do not give my permission

_____ I understand that my child will be taken to the nearest Hospital in case of an emergency. I will be contacted when this is needed.

*The Health Information contained herein __ **may** __ **may NOT** be shared with appropriate school personnel, as needed. (Nurses only share important information with staff on a need-to-know basis in order to maintain the safety and well being of the student.)

If your child has received the COVID vaccine, please submit a copy of the vaccination record to the Health Office.

Parent/Guardian Signature:_____Date:_____

Printed Name:_____