

WINDSOR LEARNING CENTER

Camille Cerciello, Ed.D.
Director

230-234 Wanaque Avenue
Pompton Lakes, New Jersey 07442
Ph: 973 839-4050 • Fax: 973 839-4052
windsorschoolsnj.com

Christopher D. Lynch, Ph.D.
Director

HEALTH INFORMATION

Student Name: _____ Date of Birth: ____/____/____

Sex: M F Grade: _____

Health Care Provider: _____

Medical History (check the ones that apply to your child):

- | | | |
|--|---|--|
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Conditions |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Dental Issues | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Bladder Problem | <input type="checkbox"/> Speech Problem |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Menstrual Issues | <input type="checkbox"/> Toileting Issues |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Muscle Disorder | <input type="checkbox"/> Vision Problem |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Neurological Disorder | |

If you have checked any of the above boxes or your son/daughter has any other medical conditions we should be aware of, please explain on the lines below:

Does your son/daughter have Asthma? ____ If **yes**, does he/she use an inhaler? ____ If an inhaler is used the State mandates an Asthma Action Plan be completed and an inhaler must be kept at school.

Allergies: (check the ones that apply to your child):

- Bees
 Foods _____
 Animals _____
 Medication: _____
 Other: _____

Does your son/daughter have any special **DIETARY** needs? _____

Is medication needed for any condition: **at home**? Yes No

Name of medication: _____ Dosage: _____

Reason needed: _____

Is medication needed for any condition: **at school**? Yes No

Name of medication: _____ Dosage: _____

Reason needed: _____

List any operations, injuries, hospitalization or prolonged illness and give dates: _____

Does your son/daughter wear glasses? Yes No

Does your son/daughter wear contact lenses? Yes No

Does your son/daughter have any health insurance including NJ Family Care/Medicaid, Medicare, private or other?

() **YES** My son/daughter has health insurance

() **NO** My son/daughter **does not** have health insurance. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: _____ Printed Name: _____ Date: _____

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

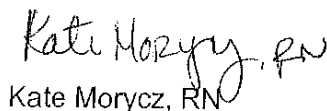
NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710

Please return this form as soon as possible.

Sincerely,



Holly Ernst, RN, CSN
Nurse



Kate Morycz, RN
Nurse