Camille Cerciello, Ed.D.
Director

WINDSOR LEARNING CENTER
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):

- ❑ Anorexia/Bulimia
- ❑ Bleeding Disorder
- ❑ Dental Issues
- ❑ Diabetes
- ❑ Eczema
- ❑ Fainting Spells
- ❑ Frequent Ear Infections
- ❑ Headaches
- ❑ Hearing Problem
- ❑ Heart Condition
- ❑ Kidney/Bladder Problem
- ❑ Menstrual Issues
- ❑ Muscle Disorder
- ❑ Neurological Disorder
- ❑ Orthopedic Conditions
- ❑ Scoliosis
- ❑ Seizures
- ❑ Speech Problem
- ❑ Toileting Issues
- ❑ Vision Problem

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