Camille Cerciello, Ed.D.
Director

WINDSOR SCHOOL
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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

**If your son/daughter has had any recent immunizations please list and attach a copy of the most recent immunization records.**

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,

Anne Marie Kelly RN CSN

Anne Marie G. Kelly, RN, CSN
School Nurse