Knowlton Township Elementary School
Health Information Form SY_____

Student Name: _____ Grade/Teacher: _____

Please take a moment to provide all the necessary health information that will allow the school nurse to provide prompt quality care to your child and help your child maximize his/her academic potential in the classroom. Thank you.

Has your child been diagnosed **within the last year** with the following health problems?

Allergies	Yes	No	Ear/Hearing Problems	Yes	No
Asthma	Yes	No	Eye/Vision Problems	Yes	No
Bleeding Problems	Yes	No	Seizures	Yes	No
Diabetes	Yes	No			

If you answered yes to any of the above, please explain: _____
_____

Is your child taking **any** medications on a regular basis? Yes ____ No ____
Name of medication(s): _____
Reason for use: _____
Will medication need to be taken at school? Yes ____ No ____

*If yes, obtain **Medication Order form** from health office or district website under Health Office.

_____

I give the school nurse permission to perform a Scoliosis Screening on my 5th grade student.
Yes ____ No _____ Please initial _____

I give permission for the school nurse to communicate with my child's health care provider regarding pertinent health information.
Yes ____ No _____ Please initial _____

I acknowledge that the above information may be shared with all KTES district personnel and school bus drivers as needed to provide for my child's well-being at school. If a situation occurs in which my child needs emergency medical attention and I am unavailable to give consent, this signed statement will serve as authorization for school personnel to initiate 911 services to have my child taken to the nearest hospital. I understand every effort will be made to contact me prior to initiating care. I understand it is my responsibility to keep the school updated of changes in contact numbers.

Parent/Guardian Signature _____ Date_____

Does this child have any health insurance including NJ Family Care/Medicaid, Medicare, private or other?

____**YES,** my child has health insurance. Name of Insurance Carrier _____
(No signature required below if you have health insurance)
____ **NO,** my child does not have health insurance. You may release my name and address to the NJ Family Care 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, call 800-701-0710 or visit www.njfamilycare.org to apply online.