

Cape May County Technical High School
New Applicant Health History

Student Name: _____ D.O.B. ___/___/___ Current School: _____ Grade: _____

Is your child applying for enrollment in Cape May Technical School (check one):

Full day high school program Partial day (half day) career/technical, if so name of other school: _____

Student's Physician: _____ Telephone: _____

Student's Dentist: _____ Telephone: _____

Does child have Health Insurance?

YES ___ If Yes, name of insurance company: _____

NO ___ 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 NJFamily Care Program to contact me about health insurance.

Signature: _____ Printed Name: _____ Date: ___/___/___

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

Check health conditions your child has: Only pertinent health conditions will be shared with teaching and guidance staff.

Medication allergy: list _____ Latex allergy (medical gloves, tapes, etc) NO YES

Food allergy: List: _____ If exposed, does your child require emergency epinephrine medication? NO YES If yes, please use the school forms for self-administering epinephrine.

Insect allergies (bees, wasps, etc.): Type of reaction and insects allergic to: _____
If exposed, does your child require emergency epinephrine medication? NO YES If yes, please use the school forms for self-administering epinephrine.

Diabetes: Insulin dependent? NO YES (Please provide the school nurse with a Diabetic Health Care Plan)

Seizure Disorder: date of last seizure, and aura: _____ Medication: _____

Asthma: Carries inhaler? NO YES If yes, please use the school forms for self-administering asthma inhaler.

Bleeding disorder: name/type of disorder: _____

ADHD/ADD Medication: _____ If administered at school, call nurse for medication forms.

Migraine headaches evaluated by a physician. Medication: _____

Vision: glasses contacts color deficiency Nystagmus Low vision, blindness, etc:

Type: _____

Hearing difficulty: which ear: ___Right ___Left ___Both Hearing aids worn? NO YES

Needs to have other adaptive devices (wheelchair, leg braces, etc): Indicate type: _____

Mental/emotional health diagnosis: _____ Share information with teachers? YES NO

Hospitalizations, surgeries, injuries or illnesses the **past 12 months**. Explain: _____

Other problem(s) not listed above. Explain: _____

Medications taken (indicate name of medications, doses and times taken): _____

In the event of a medical emergency, your child will be transported to the nearest hospital emergency room. Please complete the following information in the event your child is injured or ill.

Parent/guardian Name: _____ Address: _____

Street Town/City Zip code

Mailing address (if different from above): _____

Home Telephone: _____ Work Telephone: _____ Cell: _____

In the event we are unable to reach you, contact:

Name: _____ Relationship: _____ Home: _____ Work: _____

I give my permission for the school nurse to administer acetaminophen 650 mg. to my child for: headache, menstrual cramps, minor muscle aches/soreness, etc.

Parent/guardian signature: _____ Date: _____

Cape May Technical High School
188 Crest Haven Road
Cape May Court House, New Jersey 08210
Admissions Office: (609) 465-2161 ext. 691

Communication of Student Health Needs to Transportation Coordinator

(Complete this page only if your child will be enrolled in the high school full day program, and only if, your child has a medical condition you want the bus driver to know about.)

Dear Parent/Guardian,

As transportation staff may change, or be substituted, it may be important for your child's bus driver to know of your child's medical condition and emergency contact information. This form will serve to communicate any special health concerns or treatments to your child's bus coordinator. Return this form to the Admissions Office in person or postal mail. Please do not return this form with your child as such papers may be lost in transit.

Sincerely,
Lynda Zipparo, School Nurse

***** Parent/Guardian completes the information below*****

Student's name (print): _____ D.O.B. ____/____/____ Grade: _____

Name of Bus Transportation Company: _____ Bus number: _____

Seizure Disorder List medications taken to control seizures, if any: _____

Insulin Dependent Diabetic: Must have glucose source available (i.e. glucose gel, honey, cake icing)

Asthmatic needs to carry inhaler: Name of inhaler: _____ Dose:# ____ inhalations taken

Life Threatening Allergy

My child needs to self-administer his/her prescribed auto-injector **epinephrine** if exposed to:

Food(s): _____ Insects/bees: _____ Latex: _____ Other: _____

Bleeding Disorder: name/type of disorder: _____

Medication Allergies: _____ Is child allergic to latex? NO YES

Other medical condition(s) you want the bus driver to know: _____

In emergency contact: Parent/Guardian: _____

Telephone(s) Home: _____ Work: _____ Cell: _____

Street Address: _____ City/town: _____

If unable to reach parent or guardian, contact:

Name: _____ Telephone: Home: _____ Work: _____ Cell: _____

Your child's Primary Care Physician's name: _____ Telephone: _____

***** FOR OFFICE USE ONLY*****

Note for School Nurse: Send "Original" to Bus Transportation Coordinator, copy to student chart.

9/2009