Cape May County Technical High School: Health Information

Student Name (print):_____ Grade:_____ D.O.B.___/___/___

Student's Physician: _____ Telephone: _____

My child has medical health insurance: Name of insurance company: _____

NO, my child does not have medical health insurance. NJ Family Care provides free or low cost health insurance: call 800-701-0710 or visit www.njfamilycare.org. Release my name and address to NJFamilyCare Program to contact me about health insurance for my child. Signature: _____*Written consent required pursuant to 20U.S.C. & 1232g (b)(1) and 34 C.*

Check health conditions your child has. Only pertinent health information is shared with staff on a "need to know basis". The links attached to each condition are required by the state and need to be filled our every year.

☐ Allergy to Medication, latex, food or bee: NO / YES Please name allergen_____
If exposed, does your child require emergency epinephrine? NO / YES
https://capemaytech.com/Life%20Threatening%20Allergy%20EpiPen%20Orders.pdf

☐ Diabetes: Type: 1 OR 2 https://capemaytech.com/Diabetes%20Management%20Individual%20Plan.pdf

☐ Seizure Disorder: Type of seizure: _____ Date of last seizure: _____Does you child take medication on a daily basis for seizure? NO / YES https://capemaytech.com/Seizure%20Action%20Plan.pdf

☐ Asthma: Carries inhaler in school and/or sports? NO / YES
https://capemaytech.com/School%20Nurse%20Asthma%20Action%20Plan.pdf

☐ ADHD/ADD: Medication:_____ If administered at school your child will need this form . https://capemaytech.com/Medication%20policy%20and%20orders%20for%20school%20nurse.pdf

☐ **Vision:** ☐glasses ☐contacts ☐color deficiency ☐Nystagmus ☐Low vision, blindness,

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

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

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

_____

Medications taken on a daily basis? _____

Any additional information related to your child's health that the school nurse should know? _____

In the event of a medical emergency your child will be transported to the nearest hospital emergency room.
#1 Parent/Guardian Name: _____ Home: _____ Work: _____ Cell:_____

I give permission for the school nurse to administer, as indicated and outlined, by the school physician: (cross off items you do not want your child to receive): acetaminophen or ibuprofen, throat lozenges, topical antibiotic ointments and antiseptics, calamine lotion, hydrocortisone crème, oragel/ambesol, blister care 2nd skin, foille/watergel for burns. This will be for all 4 years at CMTS. Initial

I consent to have my child screened by the school nurse as mandated by NJ Administrative Code 6A:16-2.2 (cross off each one you would like to refuse**. Height, Weight, Blood Pressure, Vision, Hearing, Scoliosis**. This consent is good for all 4 years unless you call the school nurse. Initial:__ ___

Parent/guardian signature:_____ **Date:**_____