HAMILTON TOWNSHIP SCHOOL DISTRICT

STUDENT HEALTH INSURANCE/HISTORY

NAME OF PUPIL:_____

LAST NAME FIRST NAME M.I.

GRADE: _____ GENDER: _____ DATE OF BIRTH _____/_____/_____

Has Your Child Ever Had:	Yes	No		**Has Your Child Ever Had:**	Yes	No
Chicken Pox				Reaction to Medication		
Scarlet Fever				Reaction to infection		
Rheumatic Fever				Reaction to insect bites		
Pneumonia						
Mononucleosis				More than six colds or throat infections each year?		
Lyme Disease				More than three ear infections?		
Meningitis				Seen an Eye Doctor recently? Date: _____		
Hepatitis				Had trouble seeing?		
Diabetes				Ever worn contact lenses?		
Asthma				Worn glasses?		
Wheezing				Seen a dentist recently? Date: _____		
Nosebleeds				Had trouble with their teeth?		
Ear Infections				Wear Braces?		
Trouble hearing				Inability to control bowel or bladder?		
Worn Hearing Aids				Had a convulsion or fainting spell?		
Surgically inserted Tubes in ears? Year_____				Heart Disease?		
Seizures				Diagnosed with a heart problem or heart murmur		
Eczema						
Hives				Do you have Health Insurance?		
Seasonal Allergies				Do you have Dental Insurance?		
Sinus Problems				Do you have Vision Insurance?		
Kidney Problems						
Strep Infection						
CoVid-19 (positive test)						

LIST ANY MEDICAL/SURGICAL CARE YOUR CHILD HAS RECEIVED DURING THE PAST YEAR:

_____

_____

DOES YOUR CHILD HAVE ANY OTHER ILLNESSES OR PROBLEMS THAT WE SHOULD BE AWARE OF?_____

_____

HAS YOUR CHILD HAD AN OVERNIGHT HOSPITAL STAY? IF YES, DATE AND DESCRIBE: _____

_____

HAS YOUR CHILD EVER HAD ANY SERIOUS ACCIDENTS? (Burns, poisoning, broken bones, serious cuts?)_____

_____

ALLERGIES?(Medication/Food/Environmental): _____

If your child has allergies, please list type of allergy and type of reaction and last date of reaction (if applicable)

_____

DOES YOUR CHILD TAKE ANY MEDICATIONS?_____

DOES YOUR CHILD HAVE ANY RESTRICTIONS?_____

_____ _____/_____/_____

SIGNATURE PRINTED NAME DATE

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LAST NAME FIRST NAME M.I.

GRADE: _____ GENDER: _____ DATE OF BIRTH _____/_____/_____

DOES YOUR CHILD HAVE HEALTH INSURANCE?

Circle One

YES *If Yes, please provide the name of the insurance company on the line below:*

_____

NO *If NO, please review the following information and sign below:*

NJ Family Care 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 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).

Name of PEDIATRICIAN: _____ Phone: _____

Name of DENTIST: _____ Phone: _____

Name of ORTHODONTIST: _____ Phone: _____

Name of HOSPITAL: _____ Phone: _____

The information on these forms may be shared with School Personnel having contact with my child. In the event of an emergency this information can be shared with emergency personnel.

_____YES, please share information _____NO, please call to discuss

Initials Initials

I give permission for my child to receive the annual health screenings as required by the New Jersey Department of Education.

_____ _____/_____/_____

SIGNATURE PRINTED NAME DATE

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

_____ _____/_____/_____

SIGNATURE PRINTED NAME DATE