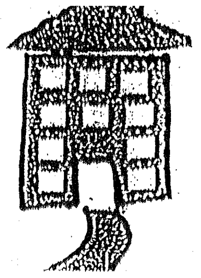
FROM THE OFFICE OF
THE SCHOOL NURSE

TEANECK COMMUNITY CHARTER SCHOOL
563 CHESTNUT AVENUE
TEANECK, NEW JERSEY 07666



STUDENT HEALTH INFORMATION

To be completed by the parent/guardian:

Student's name________________________DOB________Grade/Class_____________

Please answer "yes" or "no" with explanations as necessary.

Is your child examined yearly by a pediatric physician?________

Does your child receive regular dental care?________

Has your child ever been hospitalized?________If yes, please list the date(s) and explain the reason(s) for hospitalization____

____

Does your child have a history of broken bones?________If yes, explain____________

____

Does you child have a history of: (if yes, please explain)

Seizures________ ____

Diabetes________ ____

Heart disease/defect________ ____

Headaches________ ____

Nosebleeds________ ____

Hearing loss________ ____

Vision loss________ ____

Asthma________ **seasonal**________ **environmental**________**chronic**________

Please explain fully____

____

____

____

Allergies to foods________ ____

____

Have these food allergies caused your child to suffer anaphylactic shock?______
If yes, at what age?______ describe____

Does your child have a prescribed Epi-Pen?____________

Allergies to bee stings_________ mosquito bites_________ other bites_________
If yes, describe the reaction____

Allergies to any medications_________ If yes, explain the reaction______________

____

Does your child take prescribed medications?_________ If yes, please list them as follows:

MEDICATION	Dosage/frequency	Reason for medication

Please also list over-the-counter medications:

Please describe any skin conditions your child may have_____________________

____

Does your child have any diet restrictions?_________
Explain____

Is there any other health information you wish to explain?_________ __________

____

THIS INFORMATION IS KEPT IN THE HEALTH OFFICE UNDER STRICT CONFIDENTIALTY. If your child needs to be hospitalized during school hours, this information will be given to the medical personnel at the hospital.

Parent/Guardian signature_________________________________Date____________