GLOUCESTER CITY PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES
Student Data Sheet for Nursing Services

Grade / Homeroom Teacher_____

Student's Last Name First Date of Birth Sex

Address Home Phone Number

Mother / Guardian's Name Work Number / Cell Number Employer's Name

Father / Guardian's Name Work Number / Cell Number Employer's Name

E-Mail Address E-Mail Owner

If the school cannot contact parent, please name 2 contacts who can be called to pick up the student.

Contact's Name: Phone Number: Address:

1. _____
2. _____

Although the above recommendation of the parent will be respected as much as possible, I understand that in the final disposition of an emergency case, the judgment of the school authorities will prevail. I will notify the school in writing of any changes.

MEDICAL PERMISSION FOR SCHOOL HEALTH SERVICES

1. The school nurse will perform screenings, which include height, weight, blood pressure, hearing, and vision.
2. Every student between the ages of 10 and 18 will be screened every two years for scoliosis as required by N.J.S.A. 18A:40-4.3.

I hereby give permission for my child to receive the above described school health services as part of the school health program in the Gloucester City School District.

Parent /Guardian Signature_____ Date_____

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HEALTH HISTORY

____Heart Condition – Date of last doctor's visit for this_____
Specialist's Name: _____

____Diabetes - Date of last doctor's visit for this _____
Specialist's Name:_____

____Epilepsy / Seizures – Date of last doctor's visit for this _____
Specialist's Name: _____

____ Asthma – Date of last doctor's visit for this_____
The state of New Jersey now requires an "asthma action plan" to be on file in the school health office for any student with a diagnosis of asthma. Your child's physician completes this form. Please see the school nurse in order to obtain this important health document.

____Allergies and Reactions: (Please explain any checked conditions)

Medications_____

Insect Bites _____

Foods _____

Other _____

My child takes the following medications at home or in school: _____

Does your child have any special health needs or problems the school nurse should know? _____

Please list brother and sisters:

NAME	AGE	ATTENDS WHICH SCHOOL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby authorize an exchange of health information to occur between your physician and School Health Services Staff. The school nurse may share information with educational staff on a "need to know" basis as it impacts on the student's educational program.

_____ _____
Parent's Signature Date

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