

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

Grade / Homeroom Teacher \_\_\_\_\_

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|                     |       |               |     |
|---------------------|-------|---------------|-----|
| Student's Last Name | First | Date of Birth | Sex |
|---------------------|-------|---------------|-----|

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|         |                   |
|---------|-------------------|
| Address | Home Phone Number |
|---------|-------------------|

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

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

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|                |              |
|----------------|--------------|
| 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 \_\_\_\_\_

**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