



Student's Name _____

**BEVERLY CITY SCHOOL HEALTH OFFICE FORM
SCHOOL YEAR 2024-2025**

HEALTH HISTORY

Heart Condition _____
Asthma _____
Convulsive Disorder (Seizures) _____
Diabetes _____
Allergies _____
Food Allergies _____
Insect Allergies _____
Emotional Disorder _____
Autism Spectrum Disorder _____
Hearing Issues _____
Vision Issues _____
Speech Issues _____
Other Condition _____

If you answered yes to any of the above, please explain:

MEDICATIONS

Please list any medication your child is taking. **ALL MEDICATION ADMINISTERED BY THE SCHOOL NURSE REQUIRES A PHYSICIAN'S WRITTEN ORDER AND PARENT SIGNATURE** (Please contact the school nurse for appropriate forms)

PHYSICAL EXAMS

New Jersey Administrative Code requires each student to provide documentation of a physical examination upon enrolling in a NJ school, when applying for working papers, and before participating in athletics. In addition, the State recommends a physical at least once during each developmental stage; at early childhood (pre school through grade 3), pre-adolescence (grade 4-6), and adolescence (grades 7-12).

All medical examinations must be conducted by the family doctor (medical home or Urgent Care Center that provides physicals). If the student does not have a family doctor, please contact the school nurse. Information on New Jersey Family Care is available in the Health Office and on the school nurse's website.

(CONTINUED)

SCREENINGS

The nurse will be conducting health screenings on all students during the school year. (Screenings may include height, weight, blood pressure, vision, hearing, and/or scoliosis) Please be advised that if your student is in the 5th or 7th grade the nurse will be conducting a scoliosis examination. You will receive more information regarding this screening later in the year.

My child, _____ has permission to receive the following over the counter medication for the specific ailments.

- _____ Tylenol (weight & age appropriate) ONLY for headaches, cramps, fever (needs to be picked up)
- _____ Cough drops for cough/sore throat
- _____ Hydrocortisone cream/calamine lotion for localized skin irritation/itching
- _____ Triple antibiotic ointment for small cuts/abrasions
- _____ Visene for eye discomfort

Please indicate yes/no next to each of the above medications IN INK. Fill in all the information at the bottom of this form or it will be returned and no medication will be given.

Student's Name

Signature of Parent/Guardian

Date

Grade/Teacher

PLEASE SIGN (in ink) AND RETURN THIS FORM. No medication will be given without this written form.

Alyssa de la Pena, BSN, RN
School Nurse
609-387-2200 ext. 134