Student's Name ______________________________________

BEVERLY CITY SCHOOL HEALTH OFFICE FORM
SCHOOL YEAR 2022-2023

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*:**
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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)
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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