VERNON TOWNSHIP SCHOOL DISTRICT

Dear Parents and/or Guardians:

Please complete, sign and return to your child's teacher or the Nurse .

Student's Name_____Grade_____ DOB_____

Address_____Email _____

Mother's Name_____ Father's Name_____ Home Phone #_____

Mom's Work #_____Mom's Cell #_____Dad's Work #_____Dad's Cell # _____

Emergency Contact –Number 1- Name & Phone _____

Emergency Contact- Number 2-Name & Phone # _____

ALLERGIES: Bee Sting Allergies: Yes__ No__ **Food Allergies:** Yes__ No__ **Epi- Pen**: Yes__ No__ **Other: _____**

If your child uses an Epi-Pen or takes Medication of any kind, please contact the health office for the appropriate paperwork. These forms MUST be completed by your doctor. Kindly read and complete these forms and supply the necessary medications.

DIABETES: Yes____ No_____ **SEIZURE DISORDER:** Yes_____ No_____ **ASTHMA:** Yes____ No_____

DAILY MEDICATION/ HEALTH HISTORY: _____
INJURIES/ SURGERIES: _____
CONCUSSIONS: Yes___ No___ IMMUNIZATIONS:_____CHILDHOOD DISEASES:_____
DOCTOR_____ Doctor's PHONE #_____ DENTIST _____
Parents/Guardians should be aware of the importance of obtaining a physical examination at least once during each of the student's developmental stages: early childhood (pre-k-grade 3), pre-adolescence (grades 4-6) and adolescence (grades 7-12).

Physician's release is required for re-entry to school following communicable diseases such as strep, pink eye and chicken pox.

If you <u>DO NOT</u> want your child to have the following screenings indicate it below:

1. Vision, Hearing, Blood Pressure NO ___ 2. Height and Weight NO ____ 3. Dental Screening (if not seen by Dentist) NO____

If your child receives daily medication and will need it in school, please inform the school nurse State regulations require written physician permission to take medication during school hours. If needed these forms MUST be completed by your doctor and can be found on the VTSD website.. NO MEDICATION CAN BE GIVEN WITHOUT A DOCTOR'S WRITTEN ORDER INCLUDING OVER-THE-COUNTER MEDICATIONS SUCH AS COUGH DROPS OR TYLENOL. STUDENTS ARE NOT PERMITTED TO TRANSPORT MEDICATIONS TO AND FROM SCHOOL. A PARENT/GUARDIAN OR RESPONSIBLE ADULT MUST DELIVER AND PICK UP ALL MEDICATIONS TO BE USED BY STUDENTS IN SCHOOL.

- **In the event the doctor(s) cannot be reached, you have my permission, and I hereby designate you my agent, to call any regularly licensed physician of the State of New Jersey. I hereby release you from any claim arising out of the doctor's actions, and I assume and agree to pay the doctor's charge for services and any charges incurred at the doctor's direction.**

Does your child have Health Insurance including NJ Family Care/Medicaid, Medicare, private or other? Yes____ No____

If Yes, Name of Insurance Company_____
NJ Family Care provides free or low cost health insurance for uninsured children & certain low-income parents. For more information Call 800-701-0710 or visit www.njfamilycare.org to apply online.

- **You may release my name and address to the NJ Family Care to contact me about health insurance. (Written consent required pursuant to 20 U.S.C. § 1232g (b) (1) and 34 C.F.R. 99.30 (b)**
- **I give permission for any important information to be shared with the necessary school personnel to insure my child's safety.**

_____ _____ _____

Signature of Parent or Guardian **Printed Name of Parent or Guardian** **Date**

PLEASE USE OTHER SIDE OF FORM FOR ANY ADDITIONAL INFORMATION