Tranquility Adventist School

"TAS LOVES Growth"

3 Academy Lane, Andover, NJ 07821
908-852-1391
tranquilityschool.com

School Health History Form

Student Name_____Grade_____Date of Birth_____

DISEASE/DISORDER HISTORY OR ILLNESS

	Yes	No		Yes	No
Allergies/Environmental			Endocrine Disorder		
Allergies/Food			Head or Spinal Injury		
Allergies/Insect Stings or Bees			Headaches/Migraines		
Allergies/Latex			Hearing Impairment/Hearing Loss		
Allergies/Medications			Heart Defect or Disease		
Allergies/Other			Hepatitis or Liver Problem		
Asthma/Breathing Disorder			Hypertension		
Behavioral Disorder			Immune System Disorder		
Bladder/Kidney Disorder			Mental Health Condition		
Bleeding/Clotting Disorder			Mobility Limitation		
Bone/Joint/Muscular Disorder			Neurodevelopmental Disorder (ADD/ADHD/ASD)		
Cancer			Scoliosis		
Convulsions/Epilepsy/Seizure			Skin Condition		
Developmental Disorder			Urinary/Bladder/Kidney Disorder		
Dizziness or Fainting			Speech Disorder		
Diabetes			Surgery or Hospitalization		
Dietary Restriction			Vision or Eye Disorder (wears glasses)		
Digestive/Bowel Disorder			Other (explain below)		
Eating Disorder					

Other Medical Conditions we should know about:

_____

Was a medical evaluation performed for any condition/disorder checked 'yes'? Yes_____ No_____

Does your child have any medical condition that would limit normal activities including physical education and outdoor play?_____

My child is under a doctor's care for Asthma: Yes_____ No_____

*__An *Asthma Action Plan* form will need to be completed by the Doctor.__

My child is under a doctor's care for severe allergy? Yes_____ No_____

Was an Epi-Pen prescribed?: Yes_____No _____

Please describe the allergic reaction: _____

*__An *Allergy Action Plan* form will need to be completed by the Doctor.__

My child is under a Doctor's care for Diabetes: Check type: Type 1_____ Type 2 _____

*__A *Diabetic Medical Management Plan* will need to be completed by the Doctor.__

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MEDICATION HISTORY

Does your child take medication on a daily basis (include homeopathic and nutritional supplements)?

Yes_____ No_____

Please list all medications taken and what the medication is for:

_____

_____

Date of Last Physical:_____ Date of Last Dental Exam:_____

Primary Physician Name:_____Phone #_____

Physician Address:_____

Dentist Name:_____Phone #_____

Dentist Address:_____

*Health Insurance Provider:_____Policy Holder_____

Policy/Group #_____Member #_____

*If your child does not have coverage, note NJ FamilyCare provides free or low-cost health insurance for uninsured children and certain low income parents. For more info call 800-01-0710 or visit www.njfamilycare.org to apply online.

CONSENT TO SHARE INFORMATION: The principal and/or school nurse has my permission to share medical information listed with pertinent staff on a need-to-know basis.

Yes_____ No_____Parent Signature_____

EMERGENCY CONSENT:

I (We), the undersigned parent(s)/guardian(s) of the above minor do hereby authorize the designated Tranquility Adventist School staff to seek emergency medical care including surgical treatment, anesthesia, or any required diagnostic test in the case of injury/illness incurred while in school or participating in the school-sponsored activities in the event that I (we) cannot be reached to give consent to emergency personnel. I understand that I am responsible for all medical expenses. This consent covers the current school year only. For changes request a new form. A photocopy of this authorization shall be considered as effective and valid as the original.

Preferred Hospital in case of Emergency_____

Parent/Guardian Signature: _____ Date: _____

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Permission Form for Nursing Services
School Year _____

To: Parent/ Guardian

From: School Nurse

Re: Nursing Services; Chapter 226 – Laws of 1991

Existing legislation provides certain nursing services and funding for full-time students in private schools. Included in these services, based on available state aid, is maintenance of student health records, hearing assessment, vision screening, height and weight measurements and scoliosis screenings. In addition, your child will receive emergency nursing services for any school related illness or injury.
Please sign the form below and return it to my office ASAP.
Thank you

PERMISSION FOR SCREENINGS

HEARING SCREENING	YES	NO
VISION SCREENING	YES	NO
SCOLIOSIS (GRADES 5-8)	YES	NO
HEIGHT AND WEIGHT/ BLOOD PRESSURE	YES	NO
EMERGENCY TREATMENT	YES	NO

Name of the student _____ **Grade** _____

Parent Signature _____ **Date**_____