Galloway Township Public Schools

101 South Reeds Road
Galloway, NJ 08205
(609) 748-1250
http://www.gtps.k12.nj.us

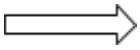
MEDICAL HISTORY QUESTIONNAIRE

This form must be completed yearly, signed by the parent or legal guardian, and returned to the school nurse. The purpose of this form is to identify problems that may affect learning.

Student's Name: _____ Date of Birth: _____ Grade: _____

Does the student have OR have a history of:	NO	YES	*If YES, Please explain*:
Allergies (Food, Drug, Seasonal, OR Reaction to bee-sting)			
Asthma			
Neurological or Mental Health Issues			
Epilepsy OR Seizure Disorder (if yes, please indicate date of last seizure)			
Heart Condition			
Serious Injury (Dislocation, Fractures, OR Concussion)			
Physical OR Sport Related Restrictions			
Medication on a Regular Basis (Please list name of medication & associated condition)			
Glasses/Contacts OR Hearing Aids/Ear Tubes Last Eye Exam (if applicable):			
Any Other Medical Problems OR Restrictions (Diabetes, Ear Infection, UTI, Etc.)			
The following question is required by the New Jersey Department of Education:			
Does your child have Health Insurance?			*If YES, Name of Insurance:*
If No, NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online.			
Healthcare Provider Name:_____			

PLEASE COMPLETE <u>BOTH</u> SIDES



The information on this form may be shared with School Personnel having contact with my child. In the event of an emergency, this information may also be given to ambulance/hospital personnel.

In the event that the parents/guardians or health care provider cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Parent/Guardian Signature: _____ **Date:** _____

Printed Name: _____
Written consent required pursuant to 20 U.S.C. § 1232g (b) (1) and 34 C.F.R. 99.30 (b).

Health Screenings - Your child will have a limited health screening, which will consist of measuring the height, weight and blood pressure, as well as basic vision, color vision and hearing screening. This will be performed by the school nurse during the current school year as per state and district requirements. A referral will be sent home if your child requires follow-up by their health care provider. In addition, students in grades 5 and above will be assessed for scoliosis during their health screening.

PLEASE COMPLETE BELOW REGARDING YOUR CHILD'S HEALTH SCREENING:

☐ **NO, I DO NOT** wish for my child to receive a health screening in school. This screening will be conducted by my child's health care provider. I understand that this request must be renewed each school year.

☐ **YES, I DO** wish for my child to receive a health screening in school.

Parent/Guardian Signature: _____ **Date:** _____