PISCATAWAY
TOWNSHIP SCHOOLS

1515 Stelton Road
Piscataway, NJ 08854
732 572-2289 ext. 2520
Fax 732 572-4577
www.piscatawayschools.org

Dr. Frank Ranelli
Superintendent of Schools
Deborah I. Dawson, Psy.D.
Supervisor of K-8 Counseling and Health Services

Health History/Record Update

Pupil's Name_____ _____
Last First Middle Grade (as of September)

Address_____ Date of Birth _____ Sex_____

Father's Name_____ Home Telephone_____ Cell #_____

Mother's Name_____ Home Telephone_____ Cell #_____

Guardian_____ Home Telephone_____ Cell #_____

The information provided in this update takes the place of any previous information. Health information will be shared with essential staff to assist in your child achieving educational goals.

HEALTH HISTORY			DATE	HEALTH HISTORY			DATE	HEALTH HISTORY	DATE
Allergy – Specify	Y	N		Eczema	Y	N		**Injuries/Broken Bones/Stitches (List)**	
				Eyeglasses/Contacts	Y	N			
				Hearing Aid	Y	N			
				Hearing Difficulties	Y	N			
				Heart Disease	Y	N			
Asthma	Y	N		Hepatitis	Y	N			
Autism Spectrum Disorder	Y	N		Hematological Disorder	Y	N		**Operations (List)**	
Auto Immune Disorders	Y	N		Juvenile Rheumatoid Arthritis	Y	N			
Chronic Otitis Media (Ear Infection)	Y	N		Lyme Disease	Y	N			
Congenital Disorder	Y	N		Mononucleosis	Y	N			
Convulsive Disorder	Y	N		Neuromuscular Disorder	Y	N		**Hospitalizations (List)**	
Diabetes	Y	N		Strep Infections	Y	N			
Drug Allergies - Specify	Y	N		Other Illnesses - Specify	Y	N			

MEDICAL RESTRICTIONS (Attach Physician's Note)	**CURRENT MEDICATIONS** (Prescriptions, Inhaler, EpiPen, etc.)

List all Children in Family (Oldest to Youngest)

Last Name/First Name	Birthdate	Last Name/FirstName	Birthdate

Signature of Parent/Guardian_____ Date_____

Any additional information can be attached to this form.

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Dear Parents/Guardians:

Food allergies affect children in many ways, with reactions ranging from itching or a rash to hives and difficulty breathing. If you notify us of your child's food allergy, food service personnel will be alerted when your child checks out in the food line.

Please complete the form below and return it to the school nurse, who in turn will send the form to Sodexo School Services at the High School (732-981-0700 ext. 2289). **A new form must be completed each school year.** Once the form is returned, the allergy information will be entered into the computer system by Sodexo's staff. The food allergy information will be entered onto your child's health record as well. **If your child cannot drink milk and you would like to substitute juice for milk, a doctor's note is required.** Please attach the note from your child's doctor to this form when you return it to the nurse.

When your child enters his/her ID number at check out a "Dietary Notice" of food allergies will appear. This alerts food service personnel that this food item should not appear on your child's tray. If it does, food service personnel will remove the food and talk with your child.

You should be aware, however, that this system may not identify allergens that are ingredients in other foods, such as chicken nuggets or baked goods.

It is hoped that this service will assist with the health and well being of your child. However, this service is not intended to replace parental responsibility for insuring that their child makes appropriate food selections from the school cafeteria.

Sincerely,

Deidre Ortiz
Director of Pupil Services

Jim Giannakis
Sodexo Food Service Manager

Complete and Return to the Nurse at Your Child's School

A new form must be completed each school year.

* * * * * * * * * * * * * *

Child's Name _____ ID Number _____ School _____ Grade _____

_____My Child has the following **food allergies** (do not include personal, religious or cultural preference):

_____

_____My child has no food allergies.

I understand that this information will be entered into the Sodexo School Services system and onto my child's health record.

_____ _____

Signature of Parent/Guardian Date

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PHYSICAL EXAMINATION FORM

Pupil's Name_____ Birthdate_____

School_____ Grade_____

Immunizations DTP_____DT_____ Td _____ Tdap _____

Polio_____Meningococcal_____

MMR_____ MMR_____ Hep B_____ Heb B_____ Hep B_____

Varicella_____ HIB_____ PCV_____

Pneumococcal Conjugate_____ Influenza_____

Mantoux Tuberculin Skin Test: Date Administered_____Date Read_____ Results_____ mm

Last Lead Test_____ Lead Test Results_____

Height_____ Weight_____Blood Pressure_____ Hearing_____ Vision_____

Nutrition_____ Skin_____ Head_____ Eyes_____ Ears_____ Nose_____

Oral (Teeth/Gums)_____ Throat_____ Neck_____ Heart_____ Lungs _____

Abdomen/Hernia_____ Genitalia_____ Extremeties_____ Orthopedic_____

Scoliosis_____ Remarks_____ Neurological_____CBC_____ Urinalysis_____

History of Illness/Injury_____

Medication_____

Participation in Physical Education/Sports/Activities_____

Remarks/Impressions/Summary_____

Physician's Signature_____

Date of Exam_____

Physician's Stamp

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MEDICATION ADMINISTRATION REQUEST

Student's Name_____

Grade_____ Date of Birth_____ Teacher/Homeroom_____

TO BE FILLED OUT BY HEALTHCARE PROVIDER:

Please administer the following medication
to the above-named student as prescribed below:

Medication_____ Dosage_____

Time to be Administered_____

Start Date_____ Stop Date_____

Diagnosis_____

Possible Side Effects_____

If PRN, for signs and symptoms_____

Healthcare Provider Stamp below:

_____
Signature of Healthcare Provider

Date Effective_____

TO BE FILLED OUT BY PARENT/GUARDIAN:

_____My child **is** to receive the prescribed medication on "half days".
_____My child **is not** to receive the prescribed medication on "half days".

I request that the above medication be administered to my child.

_____ Date_____
Signature of Parent/Guardian

This completed form, along with the medication, must be hand delivered to the school nurse by the parent/guardian. For safety and the prevention of errors, pupils may not carry medication with them during the school day. The medication must be in the original container and labeled by the pharmacy or medical provider if it is a prescription medication.

REQUESTS ARE EFFECTIVE FOR ONE SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY