CEDAR GROVE PUBLIC SCHOOLS
HEALTH SERVICE DEPARTMENT

ANNUAL HEALTH UPDATE

PLEASE RETURN TO THE SCHOOL NURSE ON THE FIRST DAY OF SCHOOL

1. Child's Name_____ Teacher_____ Grade_____
2. Has your child had any serious accidents, illnesses, or surgery over the summer? _____
   If yes, explain_____
3. List any immunizations your child has had during the past 12 months (Doctor's note must be presented indicating date and type of immunization)_____
4. Is your child taking medication for any reason (excluding vitamins)? _____
   Is yes, explain: Medication and Reason:_____
   (If confidential, please contact School Nurse)
5. Does your child have any medical or physical problems (i.e., diabetes, seizure disorder, bleeding tendencies, tires easily, headaches, nosebleeds, physical limitations, etc.)? _____
   Please explain_____
   (Confidential concerns should be addressed with the School Nurse)
6. Does your child have any allergies to medications, foods, insects, animals, pollens? If yes, please explain_____
7. Does your child have asthma? If yes, please explain the care required_____
   _____
8. Does your child wear glasses? _____ Contacts?_____ If so, is the correction for near and/or far vision?_____ When is your child to wear glasses? _____
   _____
9. Is there any additional information about your child's health, development, behavior, family, or home life that you would like the school to be aware of? _____
   _____

I would like a conference with the School Nurse – Yes_____ No_____

As parent/guardian of the above named student, I hereby authorize the release of pertinent medical information (i.e. conditions, allergies, and treatment regimes) to be exchanged among appropriate professional staff involved in the care of the above named student. This consent is valid in the Cedar Grove School District and is intended to allow the staff to better serve my child. I will discuss confidential information with the School Nurse.

Signature of Parent/Guardian_____ Date _____