

Oradell Public School District

Annual Health Update

Child's Name \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

Has your child had any serious accidents, injuries, illnesses or surgery over the summer? If yes, please explain: \_\_\_\_\_

List any immunizations or injections your child has had during the past 12 months. **(Please note: Doctor's certificate must be presented indicating date and type of immunization)** \_\_\_\_\_

Is your child taking medication for any reason (excluding vitamins?) \_\_\_ If yes, please explain: Medication \_\_\_\_\_ and reason \_\_\_\_\_

Does your child have any medical or physical problems (i.e. diabetes, seizure disorder, bleeding tendencies, tires easily, headaches, nosebleeds, physical limitations?) Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any allergies to medications, food, insects, animals or pollen? If yes, please explain: \_\_\_\_\_  
Please see school nurse regarding related paperwork.

Does your child have asthma? \_\_\_\_ If so, please see school nurse regarding required paperwork.

Does your child wear glasses? \_\_\_\_ Contacts \_\_\_\_ If so, is the correction for near and/or far vision? \_\_\_\_ When is your child to wear glasses? \_\_\_\_ Date of last examination \_\_\_\_ Date of last prescription change \_\_\_\_

Is there any additional information about your child's health, development, behavior, family or home life that you want the school to be aware of?  
\_\_\_\_\_  
\_\_\_\_\_

As the 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 Oradell public school District and is intended to allow the staff to better serve my child.

Signature of Parent/Guardian \_\_\_\_\_

Date: \_\_\_\_\_