

CHERRY HILL PUBLIC SCHOOLS

School Nurse Health Record Summary

Student's Name _____ Date of Birth _____

Grade _____ Homeroom Teacher/Team/LC _____ Date _____

1. Does your child take medication(s) on a regular basis (at home or school)? Yes _____ No _____

If yes, please list medication(s) and reason(s) for medication(s):

2. Has your child had any accidents, injuries, operations, or serious illness over the past year? Yes _____ No _____

If yes, please explain:

3. Does your child have any allergies and/or chronic health issues? Yes _____ No _____

If yes, please explain:

4. Has your child had any vaccinations in the past year? Yes _____ No _____

If yes, please list the vaccinations and provide documentation from your child's doctor or advanced practice nurse:

5. Have there been any other changes in your child's health status? Yes _____ No _____

If yes, please explain:

6. Name and phone number of student's primary health care provider:

7. Name and phone number of student's dentist:

8. Preferred Hospital (transport squad determines the hospital):

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons named on this card, or parents 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. Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

Yes _____ If Yes, name of insurance company: _____

No _____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents.

For more information call 1(800)701-0710 or visit www.njfamilycare.org to apply online.

If No, you may release my name and address to the NJ FamilyCare Program to contact me about health insurance. Yes _____ No _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Date: _____

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Emergency Contact Information

Student information:

Student's last name	Student's first name	Date of birth	Teacher/Grade
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Street address	Home phone
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Parent/Guardian Information:

Name	Relationship	Work Phone	Cell Phone
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Name	Relationship	Work Phone	Cell Phone
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Student's Siblings in ANY Cherry Hill Public School:

Sibling's last name	Sibling's first name	School/grade
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Sibling's last name	Sibling's first name	School/grade
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Sibling's last name	Sibling's first name	School/grade
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***if you need more room, please attach a separate sheet of paper

Emergency Contact Information:

List two nearby neighbors or relatives who would assume responsibility for your child if we cannot reach you:

Name	Relationship	Address	Phone
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Name	Relationship	Address	Phone
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Additional Information:

Please indicate any priority order for calling parent/guardian and emergency contacts or any other information you feel necessary:
