**2016-2017**

**STUDENT HEALTH QUESTIONNAIRE**

**&**

**MEDICAL CONSENTS**

Student name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M / F Grade: \_\_\_\_\_

*(please print) (circle one)*

*Does your child have:*

YES NO

Allergies to food \_\_\_\_\_ \_\_\_\_\_

Allergies to medication \_\_\_\_\_ \_\_\_\_\_

Allergy to latex \_\_\_\_\_ \_\_\_\_\_

Allergy to bee stings \_\_\_\_\_ \_\_\_\_\_

Asthma \_\_\_\_\_ \_\_\_\_\_

Diabetes \_\_\_\_\_ \_\_\_\_\_

Seizure disorder \_\_\_\_\_ \_\_\_\_\_

Heart problem \_\_\_\_\_ \_\_\_\_\_

Neurological problem \_\_\_\_\_ \_\_\_\_\_

Scoliosis \_\_\_\_\_ \_\_\_\_\_

Surgery (recent) \_\_\_\_\_ \_\_\_\_\_

Stitches (over summer) \_\_\_\_\_ \_\_\_\_\_

Fractures (over summer) \_\_\_\_\_ \_\_\_\_\_

Daily medication \_\_\_\_\_ \_\_\_\_\_

Please explain all “Yes” responses:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of lead testing/results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have health insurance including private, NJ Family Care/Medicaid, Medicare or other?

**YES My child has health insurance.**

*Insurance Company:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name of Insured:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Policy Number:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Group Number:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NO**  **My child does *not* have health insurance.** Please note: NJ FamilyCare provides free or low

cost health insurance for uninsured children and certain low income parents. For more

information, or to apply online, visit [www.njfamilycare.org](http://www.njfamilycare.org) or call 1-800-701-0710.

If you would like PCS to give your name and address to the *NJ FamilyCare Program,* so

that they can send you information about health insurance, please sign below:

**Princeton Charter School**

**Consent for Release of Medical Information**

**2016 - 2017**

\_\_\_\_\_\_\_\_\_\_\_ I give permission for the school nurse to release the above information to

faculty or staff of Princeton Charter School for educational or

safety purposes.

\_\_\_\_\_\_\_\_\_\_\_ I give permission for the school nurse to obtain pertinent medical

information from my child’s primary care physician. Examples include

immunization record, health history, or medication information.

\_\_\_\_\_\_\_\_\_\_\_\_ I do **not** wish any of the above information to be released to staff

other than the school nurse.

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_

Parent Name: (*please print*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Princeton Charter School**

**Consent for Emergency Medical Treatment**

**2016-2017**

In case of accident or serious illness, I request the school nurse to contact me. If the

school is unable to reach me, I hereby authorize the school to call the physician indicated

below and to follow his/her instructions. If it is impossible to contact this physician,

I give permission for my child to be transferred to the closest Emergency Room (ER) or trauma center (if necessary) where the ER doctor may assess, diagnose, and treat in order to provide

comfort. Note: Surgical intervention will require parental/guardian permission unless the

illness is life-threatening.

Family Physician name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_