

Academy Learning Center Student Health Form

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last) _____ (First) _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____ / ____ / ____
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Child's Health Insurance Carrier _____		
Parent/Guardian Name _____	Home Telephone Number _____	Work Telephone/Cell Phone Number _____	
Parent/Guardian Name _____	Home Telephone Number _____	Work Telephone/Cell Phone Number _____	

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date _____	This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No
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SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: _____	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormalities Noted: _____	Weight (must be taken within 30 days for WIC) _____
	Height (must be taken within 30 days for WIC) _____
	Head Circumference (if <2 Years) _____
	Blood Pressure (if ≥3 Years) _____

IMMUNIZATIONS

- Immunization Record Attached
 Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Medications/Treatments • List medications/treatments: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Limitations to Physical Activity • List limitations/special considerations: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Special Equipment Needs • List items necessary for daily activities _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Allergies/Sensitivities • List allergies: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Special Diet/Vitamin & Mineral Supplements • List dietary specifications: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for: _____	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print) _____	Health Care Provider Stamp: _____
Signature/Date _____	