Berlin Township Schools

Yearly Medical Update

Child's Name:_____ Grade/Teacher:_____

Family Doctor:_____ Office #:_____

1. Does your child take medication on a regular basis? _____Yes _____No. If yes, please indicate the exact name and reason:_____
    a. Will medication be needed at school? _____ Yes _____No

2. Does your child any corrective/assistive devices? _____Yes _____ No
    a. _____Glasses _____Hearing Aide/Device _____Orthopedic Brace

3. PLEASE LIST ANY MEDICAL PROBLEMS or CONDITIONS INCLUDING ALLERGIES:_____
    _____
    _____
    _____

4. Does your child have specific food allergies? _____ Yes _____ No If yes, please describe:_____

5. Does your child require an epi-pen for any allergies? _____ Yes _____ No If yes, please explain:_____

6. Does your child have any physical limitations? _____ Yes _____ No If yes, please explain:_____

Please list the telephone numbers in order of importance to call between 8:00am and 3:00pm in case your child is sick and needs to be picked up from school. These are the 1st numbers we will use in case of an emergency.

Name/Relationship	**Phone Number**
1._____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Please indicate your primary language and preferred method of communication with the School Nurse.

Primary Language of Parent/Guardian _____**Email** _____**Telephone** _____**Text** _____

I GIVE PERMISSION FOR PERTINENT MEDICAL INFORMATION TO BE SHARED WITH APPROPRIATE STAFF IN ORDER TO ENHANCE YOUR CHILD'S EDUCATION AND SAFETY.

_____YES _____NO **Parent/Guardian Signature:**_____

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**Please see other side (over)

Health Screening Permission Form

The State of NJ requires schools to perform yearly health screenings. The purpose of these screenings is for early detection of problems which may affect your child's health and/or learning. Listed below are the screening services that are provided at each grade level. **Please inform the school nurse in writing if you do not wish for your child to participate in these services.**

Height/weight/Blood Pressure – Grades K-8th

Vision Screening – Grades K, 2,4,6, & 8

Hearing Screening – Grades K,1,2,3,&7

Scoliosis Screening – Grades 5 & 7

Please contact your school nurse if any information changes during the year. We look forward to a happy and healthy year with your student. By signing below, I agree all medical information is up to date and give permission for my student's yearly screening.

Parent/Guardian
Signature_____Date_____

(OVER)

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