MEDICAL INFORMATION

1. Please note any medical problems (allergies, asthma, etc.) of which we should be aware. Also, note any special instructions related to these problems.

   Child's Name_____ Grade/Teacher_____

   Medical Condition(s) _____

2. Permission is given for routine screening (Ht., Wt., Vision, Hearing, B.P., Scoliosis) to be done by the school nurse and medical information to be shared with necessary staff/faculty. Signature: _____ Date:_____

3. **Do your children have health insurance including NJ Family Care/Medicaid, Medicare, private or other?**

   Yes _____ Name/address of insurance company: _____

   _____

   Yes_____No _____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilcare.org to apply online. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: _____ Printed Name:_____Date:_____

Written consent required pursuant to 20 U.S.C. 1232g (b)(1_ and 34 C.F.R. 99.30(b).

I affirm that everything on this form is true & accurate.

_____ _____

Parent/Guardian's Signature Date

Please return this form

This form will be kept in a confidential file in our Nurse's Office.