BENWAY SCHOOL
2016 - 2017 SCHOOL YEAR

2A.

STUDENT MEDICAL INFORMATION

Student Name _____ Date _____

Address _____ Home #_____

_____ Blood Type_____

Date of Birth _____ Soc. Sec.# (optional) _____

⇒ MEDICAL HISTORY

Please check all diseases your child has had:

_____ Measles	_____ Mumps	_____ Chicken Pox	_____ Whooping Cough
_____ Diptheria	_____ Heart Disease	_____ Hepatitis	_____ Kidney Disease
_____ Rheumatic Fever	_____ Diabetes	_____ Meningitis _	_____ German Measles
_____ Scarlet Fever	_____ Sickle Cell	_____ Lyme Disease	_____ Neuromuscular Disorders
_____ Other:_____			

PLEASE LIST FOOD, MEDICATION OR OTHER ALLERGIES/SENSITIVITIES_____

_____

Does your child have asthma as diagnosed by a physician?_____ If yes, please explain:

_____

Does your child have a history of seizures? _____If yes, type?_____

Date of last seizure:_____

⇒ MEDICAL INSURANCE INFORMATION

Insurance Company_____ Policy No._____

Whose Name (Parent/Guardian) is Medical Insurance under?_____

* IF YOU DO NOT HAVE MEDICAL INSURANCE, CAN WE GIVE YOUR CONTACT INFORMATION TO NJ FAMILY CARE SO THAT YOU MAY RECEIVE INFORMATION ON HEALTH INSURANCE? Yes____ No____

⇒ CURRENT MEDICATION

Please list ALL medications your child is taking at home or school — including inhalers and over-the-counter medications

TYPE	DOSE	TIME GIVEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

* I authorize required emergency room treatment for my child until we arrive at the hospital. Yes___ No___

* For the safety of my child, I authorize the nurse to share important health info with staff. Yes___ No___

Parent/Guardian Signature_____

OVER ⟶