



Palmyra School District
Emergency and Health Information – Annual Update

Please Print

Student Name: _____ Grade: _____ Homeroom: _____
 Home Address: _____ Phone: _____
 Date of Birth: _____ Male: ___ Female: ___ Student Lives With: Mother ___ Father ___ Both ___ Other ___
 Primary Physician: _____ Physician's Phone: _____

HEALTH INSURANCE: Does your child have health insurance? YES ___ NO ___ NJ FAMILY CARE 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.njfamilycare.org to apply online. You may release my name and address to the NJ Family Care Program to contact me regarding health insurance.

Signature: _____ Date: _____

Emergency Contacts ONLY CONTACTS LISTED ON THIS EMERGENCY CARD WILL BE PERMITTED TO PICK UP CHILD

Mother's/Guardian's Name: _____ Address: _____
(if different from Student's address)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Father's/Guardian's Name: _____ Address: _____
(if different from Student's address)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name of friend, relative or child care provider permitted to care for your child if you cannot be reached:

1. Name: _____ Relationship: _____ Phone: _____ Work or Cell Phone: _____

2. Name: _____ Relationship: _____ Phone: _____ Work or Cell Phone: _____

In case of accident or serious illness, all reasonable efforts will be made to contact the student's parent or guardian. If necessary, the Primary Care Physician and/or 911 will be called and the student sent to the nearest hospital. When a student becomes ill at school, it is the policy of the Palmyra School District to send home. Please notify the school if there are changes in this information.

Medical History

Does your child take any medication on a regular basis? Yes: ___ No: ___

If yes, please indicate the exact name of the medication, reason it was prescribed and by whom: _____

*All medications to be taken during the school day requires a Palmyra Medication Form to be completed by the Parent and Physician. This also includes inhalers for asthma. (Forms are available in the Nurse's Office)

Please check health condition(s) your child has _____ My child has no health conditions _____

<input type="checkbox"/> ADD	<input type="checkbox"/> Hemophilia/Bleeding Disorder	<input type="checkbox"/> Orthopedic Disorder
<input type="checkbox"/> ADHD	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Psychiatric/Emotional Disorder
<input type="checkbox"/> Bowel or bladder disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ulcers/Gastric Reflux
<input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> Hearing Loss _____ Tubes in Ears _____	<input type="checkbox"/> Nose Bleeds _____

For conditions checked above, Please provide additional information:

Allergies	What is your child allergic to: _____ *Is emergency medication needed at school for allergies? Yes ___ No ___ Epi-pen? Yes ___ No ___ If yes, name: _____ Check the type of allergic reaction that occurs: <input type="checkbox"/> Hives <input type="checkbox"/> Swelling <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Other _____
Asthma	Date of last episode: _____ List triggers: _____ *Medication is needed at school: <input type="checkbox"/> Daily <input type="checkbox"/> Before P.E. <input type="checkbox"/> Never <input type="checkbox"/> When symptoms occur
Seizures	Check type: <input type="checkbox"/> Febrile Only <input type="checkbox"/> Convulsive <input type="checkbox"/> Non-Convulsive When did last seizure occur? _____ Medication: _____
Heart Problems	Check type: <input type="checkbox"/> Functional Heart Murmur <input type="checkbox"/> Heart valve condition <input type="checkbox"/> Other _____ *Is exercise limited? Yes ___ No ___
Other Condition Listed	Name of Problem: _____ School Concerns: _____

Non-Prescription Pain Relievers/Fever Reducers: My child may receive

Yes No 1.) Acetaminophen (Tylenol) at the discretion of the School Nurse, in accordance with the school district protocol.

Yes No 2.) Ibuprofen (Advil) at the discretion of the School Nurse, in accordance with the school district protocol. Age 12 and over.

The State of New Jersey requires that all children age 10-18 be screened for Scoliosis (curvature of the spine) every other year.

I want my child screened for Scoliosis at school by the School Nurse.

My child will be screened for Scoliosis by our physician and I will send a report of this examination to the school.

I certify that all of the above information is correct. I consent to the release of this medical information to appropriate school staff in order to insure the safety and learning potential of my child.

 Parent/Guardian Signature

 Date