

NORTHERN HIGHLANDS REGIONAL HIGH SCHOOL
CONFIDENTIAL MEDICAL INFORMATION

Name: _____ Grade: _____

Date registered: _____ Starting Date: _____

Physician Name _____		Physician Phone Number: _____	
Check any conditions below that are applicable:		IF YES, please provide more specific information, if necessary:	
<input type="checkbox"/> Life-Threatening Allergy			
<input type="checkbox"/> Asthma			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> Food Allergy			
<input type="checkbox"/> Food Restrictions			
<input type="checkbox"/> Non-Life-Threatening Allergy			
<input type="checkbox"/> Convulsive Disorder			
<input type="checkbox"/> Heart Disease			
<input type="checkbox"/> Headaches			
<input type="checkbox"/> Hearing Problem			
<input type="checkbox"/> Seasonal Allergies			
<input type="checkbox"/> Lyme Disease			
<input type="checkbox"/> Neuromuscular Disease			
<input type="checkbox"/> Vision Problem			
Other:			
Comments: 			

In case of accident or serious illness, I request the school nurse to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated above and to follow his/her instructions. If it is impossible to contact my child's physician, the school may contact any of the emergency contacts on record and make whatever medical arrangements are necessary. While the school attempts to contact the above persons, the school will provide immediate triage and contact emergency medical services/the rescue squad when deemed necessary. This permission applies to the entire period my child is enrolled at Northern Highlands.

Health screenings will be conducted by the School Nurse when a current physical exam containing that health information is not on file in the health office. Screenings for height, weight, blood pressure, vision, hearing and scoliosis will be conducted as per New Jersey State Code (N.J.A.C. 6A: 16-2-2)

Signature of parent or guardian: _____

Date: _____

Cc: School Nurse