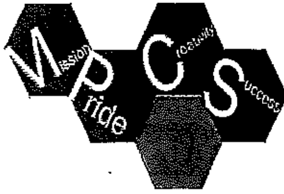
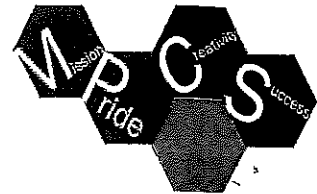


MILLVILLE PUBLIC CHARTER SCHOOL
1101 WHEATON AVENUE, SUITE 220
MILLVILLE, NJ 08332
856-506-8143



Annual Student Medical Form

Student Name: ____________________ DOB: __________ M/F ________ Grade: _______

Home Address: ____

Home Phone: ____________________ Mom's Cell: ____________________

Dad's Cell: ____________________ Mom's Work: ____________________

Dad's Work: ____________________

Which is the best phone number to call during school hours? ____________________

Emergency Contact: ____

1. Does your child take any medications? Yes No

   If yes, please explain: ____

   What time of day does your child take these medications? ____________________

2. Does your child have a history of asthma? Yes No

   If yes, is medication still required? Yes No

3. Does your child have any medical or physical problems? Yes No

   If yes, please explain: ____

4. Does your child have any allergies? Yes No

   If yes, please explain: ____

5. Is there any food that your child cannot eat? Yes No

   If yes, please explain: ____

6. Does your child have a history of convulsions or seizures? Yes No

   If yes, please explain: ____

   Names of medication(s): ____

7. Has your child ever had any serious illness, operations, dental work or accidents?

   Yes No

   If yes, please explain: ____

8. Was your child's birth considered (by your doctor) to be premature, unusually traumatic or difficult?

   Yes No

   If yes, please explain: ____

9. Has your child been exposed to toxic substances such as lead, pesticides, inhalants, etc?

Yes No

If yes, please explain: ____

10. Does your child wear glasses or contacts? Yes No

If yes, when was their last eye exam: ______________________________

11. Has your child recently had a traumatic or upsetting experience (i.e. the death of loved one, family divorce, moving to a new home, being a witness or victim of a violent act, or having a loved one acutely ill or injured)? Yes No

If yes, please explain:

____

____

12. Does your child display any signs of emotional problems (i.e. frequent uncontrolled outbursts, withdrawal, inability to relate to others, or lying)? Yes No

If yes, please explain: ____

13. Name of Doctor: _________________________ Phone: ________________

Date of last healthcare visit: ______________________________________

14. Name of Dentist: _________________________ Phone: ________________

Date of last healthcare visit: ______________________________________

15. GIRLS – Date of onset of menstruation ____________ Date of last cycle: ________

16. Is there any concerns or significant information that would be important for the school nurse or staff to know?

____

____

____

____

- ***The above health information is pertinent to the safety and well-being of your child. Please indicate below if we may advise the appropriate staff members.***

[ ] Yes, I give permission to share this information with necessary staff members.

[ ] No, I DO NOT give permission to share this information with necessary staff members.

Signature of Parent/Guardian: ______________________________ Date: ______________